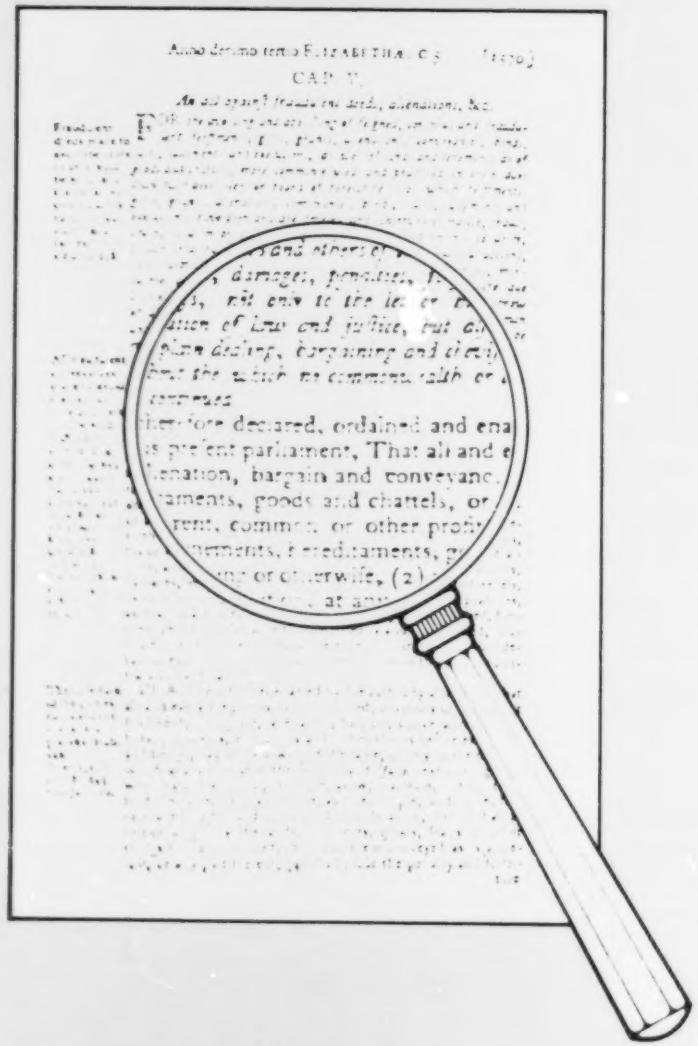
Law Reform Commission of Saskatchewan

Proposals for a New Coroners Act

Report to the Minister of Justice

Saskatchewan



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PROPOSALS FOR A NEW CORONERS ACT

Law Reform Commission of Saskatchewan
Saskatoon, Saskatchewan

Report to the Minister of Justice

September, 1984

The Law Reform Commission of Saskatchewan was established by *An Act to Establish a Law Reform Commission* proclaimed in November, 1973, and began functioning in February of 1974.

The Commissioners are:

Professor DOUGLAS A. SCHMEISER, Q.C., B.A., LL.B., LL.M., S.J.D., Chairman

Miss MARJORIE A. GERWING, Q.C., B.A., LL.B.

Mr. GORDON J. KUSKI, Q.C., LL.B.

Mr. Kenneth P. R. Hodges, B.A., LL.B. is Director of Research.

Mr. Michael J. W. Finley, B.A., M.A., LL.B. and Mr. C. Peter Thagard, LL.B. are the Legal Research Officers, and Mr. Roderick J. Wood, LL.B., LL.M., Dip. in Legislative Drafting and Mrs. Sandy Antonini-Ready, B.A., LL.B. are Legal Research Officers under contract. The secretaries are Mrs. Sandra Ritchie and Miss Pat Harasymchuk.

Mr. Eric Cline, Barrister and Solicitor of Saskatoon, Saskatchewan served as Consultant to the Commission on the review of The Coroners Act.

* * * * * *

The Law Reform Commission Act.

> 6. The commission shall take and keep under review all the law of the province, including statute law, common law and judicial decisions, with a view to its systematic development and reform, including the codification, elimination of anomalies, repeal of obsolete and unnecessary enactments, reduction in the number of separate enactments and generally the simplification and modernization of the law.

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Saskatchewan

Law Reform
Commission of
Saskatchewan

Provincial Office Building
122 Third Avenue North
Saskatoon, Canada
S7K 2H6

(306) 664-6127

To The Honourable J. Gary Lane, Q.C.
Minister of Justice

Dear Mr. Minister:

As part of its Medical-Legal Project, the Commission has reviewed The Coroners Act. The role of the coroner has changed significantly since the time when he was primarily concerned with criminal investigations. The coroner remains, however, an important public official charged with a duty to ensure that there is public scrutiny of violent and unexplained deaths in our community.

The Coroners Act has not been substantially amended since 1936. The Commission's proposals for a new Coroners Act are designed to reflect the modern role of the coroner, and facilitate better utilization of modern medical and other investigative techniques.

The Commission acknowledges the co-operation and assistance it received in preparation of this report from the Chief Coroner, Dr. S. MacMillan. The Commission is also indebted to those coroners and other officials who commented upon the Tentative Proposals for a Coroners Act. Their suggestions were of great assistance.

Pursuant to section 9 of The Law Reform Commission Act, the Commission now submits this report with the recommendation for the enactment of a new Coroners Act.

Respectfully submitted this 30th day of August, A.D. 1984.

D. A. Schmeiser

Douglas A. Schmeiser, Q.C., Chairman

Marjorie A. Gerwing, Q.C., Commissioner

Gordon J. Kuski, Q.C., Commissioner

PROPOSALS FOR A NEW CORONERS ACT

I. INTRODUCTION

1. History of the Office

The coroner system is one of the oldest institutions in our legal system. While today the office is associated with investigation of unnatural deaths, historically this function was but one aspect of the role played by the coroner. The coroner of the twelfth and thirteenth centuries performed a host of administrative and judicial duties on behalf of the Crown. The coroner had a revenue-collecting function and a broad judicial function; the investigation of deaths was of secondary importance.

The early medieval coroner conducted inquests into deaths from violence or misadventure, but also received complaints and held inquests into most allegations of criminal conduct. The inquests served a function roughly equivalent to the modern preliminary inquiry. The coroner also pronounced judgments of outlawry with respect to fugitives from justice, imposed fines and penalties for the dereliction of a variety of civic duties related to the reporting of deaths and the prosecution of offenders, and saw to forfeiture to the Crown of property of convicted felons, suicides and outlaws.

In the early thirteenth century, the new office of justice of the peace began to usurp the coroner's traditional role. The justices assumed jurisdiction to conduct preliminary inquiries in criminal cases, including those of suspected homicide, although homicide cases continued to be prosecuted by way of coroner's inquisition as well.[1] By the end of the fifteenth century, inquests were held primarily in cases where, because of manifest evidence of external violence, a felony was the suspected cause of death.

The early inquest into sudden or unexpected death "was associated with a complex and rigidly enforced procedure":

> The finder of the body, or the person first to become aware of the death, was expected to raise the hue, and the coroner was immediately sent for by the township or ville nearest which the death had taken place. On the arrival of the coroner the death was presented to him by the four neighboring townships. All the inhabitants of the township or ville nearest which the death had occurred were expected to attend, and to have secured the attendance of the finder of the body, anyone else present when death occurred, and the four nearest neighbors to the deceased, all of whom were attached to appear before the justices in eyre and were expected to find pledges to appear.[2]

To avoid the imposition of penalty, local inhabitants would inform the coroner of sudden deaths, apprehend any felon responsible, initiate prosecutions and attempt to comply with other formal requirements. If they failed in their duties, justices took "every possible opportunity to fine or amerce individuals or communities".[3] Their visits, and the coroner's office, were really part of the system of taxation.

The medieval coroner was assisted at the inquest by the jury. It originally consisted of all males over twelve years of age from the four townships, parishes or wards surrounding the location of the body, but eventually became limited to twelve men. Unlike the modern jury, which listens to the evidence in an objective manner and arrives at a verdict, the early coroner's jury brought the personal knowledge of its members and their fellow community members concerning the circumstances of the death out before the coroner; the jurors acted as

investigators and witnesses.[4] Scant reliance was placed upon the views of medical experts: "for centuries coroners and their juries were reaching their verdicts on cases of sudden death almost entirely unencumbered by medical evidence of the cause of death".[5]

The development of police forces and public prosecutors, and the growth of the jurisdiction of justices to commit persons to stand trial on homicide charges eroded the traditional function of the coroner. By the late nineteenth century a new conception of the office began to emerge. The inquest was seen not primarily as a means of investigating crime, but as a forum for determining cause of death in cases in which a medical inquiry seemed desirable. In England, the coroner's jurisdiction to investigate deaths was expanded to include any case of sudden or unexplained death, and provision was made for payment of fees to medical witnesses. However, the coroner's inquest remained a court of criminal jurisdiction, and people continued to be tried on coroners' inquisitions.

2. The Coroner System in Saskatchewan

The coroner system as it existed in England on July 15, 1870 became part of the law of the North-West Territories, and was incorporated into the law of Saskatchewan when the province was created in 1905.[6]

Saskatchewan's first *Coroners Act* was enacted in 1906.[7] It provided for the appointment of coroners by the Lieutenant Governor in Council and, like the present *Act*, did not specify any qualifications for the office.[8] Consistent with the attitude of British justices towards the coroner, this first *Act* did not encourage the coroner to investigate accidental deaths where no one could be held criminally or civilly responsible. The *Act* provided that a coroner was not to receive fees for any inquest, unless prior to the inquest he made a written declaration under oath stating that he had received information and that there was:

> reason for believing that the deceased did not come to his death from natural causes or from mere accident or mischance but came to his death from violence or unfair means or culpable or negligent conduct either of himself or of others under circumstances requiring investigation by a coroner's inquest.[9]

In addition, the Attorney General could request an inquest, and the coroner could hold an inquest upon the body of any prisoner who died in custody.[10] The function of the jury was to view the body, hear the evidence and give a verdict as to "who the deceased was and how and when he came to his death".[11]

Saskatchewan was slow to adopt the late nineteenth century English reforms of the coroner system. In the 1912-13 legislative session, the *Act* was amended to provide that the coroner could inquire into accidental death in circumstances requiring investigation.[12] In the 1921-22 session, however, the *Act* was again amended, and the 1906 position was resurrected.[13] The *Act* remained virtually unchanged until 1936. In that year a new *Coroners Act*[14] was adopted. The 1936 *Act* recognized that the coroner had an interest in investigating any unnatural death, regardless of whether "violence or unfair means or culpable or negligent conduct" could be said to have been a factor in the death. The coroner's mandate was broadened to permit him to investigate deaths "from any cause other than disease or sickness or as a result of negligence or malpractice on the part of others, or under such circumstances as require investigation".[15]

The *Act* of 1936 introduced many changes to the coroner system in Saskatchewan, and formed the basis of our present legislation. In recent years some further significant changes have been made to the coroner system. In 1978, the office of the chief coroner was established

to ensure that the system was properly administered and, toward that end, to supervise and provide instruction to coroners.[16] The jury was specifically empowered to make recommendations to avoid similar deaths in the future.[17] Persons "substantially and directly" interested in an inquest were given the right to counsel at an inquest, and the right to examine and cross-examine the witnesses.[18] In 1980, the ancient requirement that the jury must view the body themselves, rather than rely upon medical witnesses, was removed.[19]

The present *Coroners Act*[20] imposes a duty on medical practitioners, funeral directors, embalmers or anyone else with reason to believe a death has occurred under the various circumstances assumed to warrant investigation to report the death to a coroner in the locality.[21] The coroner is directed by the *Act* to take possession of the body, to view it, and to "make such further inquiry as may be required to satisfy himself whether or not an inquest is necessary".[22] If he deems an inquest unnecessary, he authorizes burial.[23] The Attorney General may, however, direct an inquest to be held.[24] A coroner must be notified of the death of a prisoner, and an inquest must be held into such a death.[25]

When a body is buried prior to an inquest, the Attorney General may authorize an inquest without exhumation where no examination or further examination of the body is necessary.[26] The Attorney General may authorize an inquest where a body cannot be found or recovered.[27]

When an inquest is to be held, a jury of six is summoned[28] and the coroner summons persons "who, in his opinion, may be able to give material evidence as to the cause of death, or as to any other matter to be inquired into at an inquest",[29] as well as any additional persons Crown counsel may wish to examine at the inquest.[30] The coroner may order that a post-mortem examination of the body be conducted.[31]

3. Survival of the Traditional Criminal Role

Committal for trial on homicide charges on the inquisition of a coroner's jury existed in Canada alongside committal after preliminary hearing until 1892. The *Criminal Code*, introduced in that year, provided that no person shall be tried upon a coroner's inquisiton.[32]

While a coroner's jury can no longer effectively charge anyone with a criminal offence, the *Code* continues to contemplate that coroners and juries will make allegations of criminal conduct against individuals as the result of evidence given at an inquest.[33] Given the traditional role of the coroner system in accusing individuals of crime, it is not surprising that, until recently, the coroner's inquest was considered a "criminal court of record".[34]

Most of the provincial statutes establishing a system for investigation of deaths do not contemplate that any criminal allegations should necessarily arise out of the system. In three provinces, an inquest may still find that a criminal act has been committed and name the presumed criminal,[35] but in Saskatchewan, like most jurisdictions, any finding of legal responsibility, whether criminal or civil in nature, is apparently precluded.[36] Until 1976, the verdict of the jury was referred to in the *Act* as an "inquisition",[37] a reference which was deleted and substituted with the more neutral term "verdict".[38] The Ontario and British Columbia statutes expressly provide that a coroner's jury shall not make any finding of legal responsibility for death or express conclusions of law.[39] The Ontario *Coroners Act* further provides that the powers conferred on a coroner to conduct an inquest shall not be construed as creating a criminal court of record.[40] The philosophy behind this provision is that the appropriate forum for making judgments as to whether individuals may be legally responsible for deaths is the judicial system, which possesses procedural safeguards that have been established to ensure that accused persons are dealt with in a fair manner. A modern system for investigation of deaths should not be seen as performing functions related to the criminal justice system.

Much of the law relating to coroners and inquests is contained in the common law, rather than statutes. While many of the common law rules remain appropriate, it must be recognized that they evolved in an era when the coroner system was concerned primarily with criminal justice. Therefore, the common law relating to coroners and inquests should be abolished, and those common law rules which remain useful or necessary re-enacted as part of the statute law.

4. Types of Systems for Investigation of Deaths

Most modern legal systems have established some mechanism for investigating sudden or unexplained death. Three basic approaches can be identified — the coroner system, which is typical in jurisdictions with a common law background; the medical examiner system, which originated in the United States as a reform of the coroner system; and the continental system, which operates in most nations with a civil law tradition.[41] Part of the difference between the systems is merely historical and incidental, but each gives different emphasis to the role of the investigating officer.

The continental system is primarily concerned with determining the cause and circumstances of death for the purpose of assigning criminal responsibility. It is an adjunct to police investigation. Upon receipt of a report of a death, the police examine deaths to accurately determine the medical cause and whether any offence was committed. The police are assisted by medical experts who are associated with the police force, usually including a pathologist. The police conduct the investigation with a view to determining if a criminal prosecution is in order.

The medical examiner system is primarily, though not exclusively, concerned with determining the medical cause of death. A qualified medical officer examines the circumstances with a view to determining the medical cause of death and reports the cause to the appropriate authorities in an effort to ensure that causes of death are accurately ascertained. Autopsies are conducted by qualified pathologists. In some jurisdictions, the medical examiner does not hold a public inquiry, but may question individuals concerning the death in private.

The coroner system, apart from the limited criminal function it retains, now exists primarily for the purpose of providing an independent investigation of the circumstances surrounding death. An important part of the coroner's role is the conduct of inquests in cases in which a public inquiry is appropriate. Cases of violent, sudden or unexplained death are reported to the coroner, who is usually a part-time official with no mandatory qualifications. The coroner or his officers investigate the death, and the coroner, as an independent official, has the power to decide whether a post-mortem examination, an exhumation or an inquest is necessary. His role is to examine all of the circumstances of the death, and not simply to see that the medical cause of death is determined. For example, he may decide that an inquest into the death is necessary in the interests of public safety because new safeguards are needed. He may also decide to hold an inquest to promote public education or to quell rumour and suspicion in the community.

The coroner system is employed in British Columbia, Saskatchewan, Ontario, Quebec, New Brunswick, Prince Edward Island and the Territories.[42] A medical examiner system is in force in Nova Scotia, Manitoba, and Alberta, although those jurisdictions also provide for public inquiry before a judicial officer in some cases.[43] Prince Edward Island has enacted legislation setting up a medical examiner system, but it is not yet proclaimed.[44] In Newfoundland, provincial judges are empowered to conduct judicial inquiries into certain deaths.[45]

Reform of the coroner system must begin with a clear identification of the purposes which it should serve. The differences in emphasis among the systems for investigation of death outlined above suggest that the proper function of such a system is not immediately obvious. The next chapter of this Report will attempt to identify the role which a modern system for investigation of deaths should play in Saskatchewan.

II. A SYSTEM FOR INVESTIGATION OF DEATHS IN MODERN PERSPECTIVE

1 The Purposes of the System

A system for investigation of deaths is not necessary to uncover crime, although it may do that in some cases. The criminal aspect of the coroner system became less important with the advent of modern police forces. As one commentator observes:

> The coroner's primary role became the accurate identification of medical causes of death and, where necessary, the holding of public inquiries in situations involving unusual or unnatural deaths. These inquiries were not conducted primarily with a view to identifying criminal activity and criminals, but rather to satisfy public concern and promote public welfare.[46]

Modern systems for the investigation of deaths are viewed as having a broader mandate than the initiation of criminal proceedings. Skilled detectives, forensic scientists, pathologists and others associated with police forces are well equipped to investigate deaths caused by criminal activity and to initiate prosecutions in the courts. The classification of the coroner's inquest as a "court of criminal record" is "historical rather than functional, and has outlasted both its accuracy and its utility".[47]

Nor should the system for investigating deaths arrive at determinations of civil liability for death. The courts, in the civil arena as well as in criminal matters, exist to perform that function.

What purpose, then, can such a system serve? The Ontario Law Reform Commission has suggested that:

> In today's sense, the coroner system serves to provide a formal means for an investigation of, and if required, a public inquiry into the circumstances surrounding a sudden or unexplained or unexpected death. In addition, the coroner system serves to allow the private and public sectors of the community to identify and implement appropriate measures designed to minimize the incidence of preventable deaths in the future. Every modern state discharges these functions in some way or another.[48]

The underlying assumption is that it is in the public interest to investigate unexpected, unnatural or unexplained deaths. There are several reasons why investigation of certain types of deaths by an independent officer is necessary.

First, determining the facts surrounding the death, the identity of the victim and the time, place and medical cause of death may be important for private purposes apart from identifying civil or criminal liability. For example, accurate determination of the medical cause of death is important to the relatives of the deceased person, who usually have a strong desire to know the medical cause of death as well as the underlying circumstances giving rise to it. An

accurate determination of the cause of death may have important ramifications with respect to insurance policies that provide double indemnity for accidental death, or prohibit recovery of benefits in a case of suicide.

Second, society at large can benefit from the investigation. Accurate statistics as to causes of death are necessary to provide a basis for allocating research funds and public health expenditures. A systematic examination of accidental and other deaths may bring to light a pattern of unsafe conditions or practices that would not become apparent in the absence of a co-ordinated effort. The inquiry may identify health and safety hazards in individual cases that require an immediate remedy.

Third, an efficient and respected system will do much to maintain public confidence that due attention and concern is afforded deaths that occur under unusual circumstances. Without such an inquiry, rumour and speculation surrounding controversial deaths can find no easy outlet. When a death occurs in an institution in which persons are under the responsibility of public officials, such as correctional facilities or mental hospitals, the public will almost invariably desire that the circumstances be examined.

The person investigating the death should have a significant degree of independence from the police and agencies of government. A system that is separate from those authorities and that allows for open, public investigation is more likely to continually prod government to enact changes necessary to prevent future deaths. Public confidence in the system can be maintained only if the public is assured that there is no conflict of interest which may prevent the coroner from carrying out his duties in an unbiased fashion.

Finally, the system can play a variety of other minor roles. It can serve an educative function by bringing notice of danger to the public. It preserves a record of the circumstances of unexplained deaths. Although it should not be regarded as an adjunct of the criminal justice system, it can serve in some cases as a safety valve when police authorities fail to uncover homicide in cases of apparent natural death.

2. Elements of the System

Several essential elements are necessary in a system that fulfils the purposes enumerated above.

(a) Reporting

There must be a duty upon individuals to bring unexplained or unnatural deaths to the attention of the appropriate officials. The legislation should clearly identify the categories of deaths which should be reported.

(b) Investigation

The system must provide for thorough investigation and employ the appropriate expertise to accomplish that purpose. Tasks requiring medical training should be performed by persons with the requisite skill and training. For example, autopsies should be performed by pathologists. Toxicologists should be employed where necessary. The tasks of investigation will be routinely delegated to those who have expertise in the field.

In investigating the circumstances surrounding a death, the best non-medical expertise available should be employed. The police should be required to assist in recording the scene of the death and other aspects of the investigation. The services of forensic scientists employed by police forces would be of obvious advantage. In many cases, the nature of the death is such that other experts should be consulted. For example, where death occurs as the result of struc-

tural collapse, engineers should be retained. The officers of the investigation system will not possess expertise in all of the methods of investigation and areas of knowledge that may be called upon in an investigation; therefore, the work must be delegated.

(c) Inquest

In some cases an investigation into the death is not enough; the public interest may require that an inquest be held.

An inquest may be necessary for one or more of the following reasons:

1. The facts surrounding the death, the cause of death or the circumstances of death are not explained after investigation. All available evidence can be put on the record at an inquest.
2. The death was apparently caused by criminal activity, but no criminal proceeding can be commenced to publicly air the facts that are ascertainable because there is not sufficient evidence to commence prosecution.
3. Dangerous practices or conditions exist which should be brought to light and with respect to which recommendations for improvement to avoid preventable deaths could usefully be made following an inquest.
4. It is necessary in the interest of public safety to educate the public as to dangerous conditions or practices to avoid preventable deaths.
5. It is necessary to publicly air the circumstances of the death because of suspicious circumstances or to end rumour and speculation surrounding the death, or because of public concern about the death.

The inquest, like the investigation system itself, does more than simply determine the medical cause of death which can be done better by medical experts than lay jurors. As one commentator writes:

> The inquest, however, can serve a valuable, if collateral, purpose. It can assuage the doubts, fears, and legitimate curiosity of the victim's family and the general public, as to how a relative and/or fellow citizen met his demise. The public inquest also gives a suspect the opportunity to clear his name, justifying the lack of further legal action which aggrieved families all-too-often are tempted to label "whitewash".[49]

Of the approximately 10,000 deaths which occur annually in Saskatchewan, about 1,800 are investigated by coroners. Some 1,300 autopsies are performed, and 50 inquests are held per year.[50]

3. A Coroner's System or Medical Examiner's System?

The role of the system for investigation of deaths is a broad social one. Its goals are to avoid preventable deaths by convincing governments, industries and individuals to alter dangerous practices or conditions, and to ensure that deaths are adequately explained. The investigation system must examine such questions as whether or not bridges were properly constructed and maintained, whether or not safety standards on construction sites were ade-

quate, whether or not mine safety needs improvement, and whether or not wards of the state are properly cared for. In examining these questions, the investigative officers must go beyond the province of the police investigator, the prosecutor, and the medical expert. The expertise of the police, doctors in different branches of medicine, experts in various other fields, and the common sense of the public are needed to properly appraise the circumstances of a death. As one famous coroner has put it:

> Most people misunderstand the role of the coroner, confusing him with the pathologist; so when I became a coroner I was continually being asked how I could stand cutting up dead bodies. Actually coroners never do post-mortems and the coroner's role largely consists of examining the circumstances of the death. If there is some question of the cause of death, the coroner will order a pathologist to do an autopsy.[51]

The emphasis of the medical examiner's system on the appointment of medical specialists to direct investigations must be seen in an historical context. The system originated in the United States as a response to inadequately conceived and supported coroner's systems. Coroners in jurisdictions that opted for a medical examiner's system often were not qualified in any way to direct investigations or conduct inquests; they were not trained to conduct autopsies, and other experts were not consulted. The system did not even provide reliable evidence of the immediate cause of death. The medical examiner's system arose in response to that situation. But it is not one that has ever existed in Saskatchewan.

Because the medical examiner's system emphasizes determination of the medical cause of death, its proponents criticize the coroner's system which allegedly "allows a layman to make the crucial and difficult determination of cause and manner of death which may be associated with violent or suspicious circumstances".[52] The lay jurors at a coroner's inquest are viewed as equally incompetent. It is true that lay jurors should not literally "perform tasks that demand expert training" and should not make the "crucial and difficult determination of the cause and manner of death" alone. In such matters, they should be assisted by medical experts who perform medical tasks and give medical advice. Certainly, in fulfilling the function of determining the medical cause of death, the best medical expertise available should be employed. The system will not be effective unless, as a practical administrative matter, the investigation system has available to it properly trained forensic pathologists and other medical experts. But it does not follow that conduct of the investigation should be assigned to medical personnel as the chief officers of the system. Some commentators suggest that coroners should be lawyers,[53] and in England a coroner must be either a lawyer or a medical practitioner.[54] One eminent authority on the coroner's system has even recommended that coroners possess as minimum requirements "qualifications, and preferably university degrees, in both law and medicine, with post-graduate experience in both criminal courts and forensic pathology".[55]

In the Commission's opinion, it is neither necessary nor desirable to restrict the office of coroner to persons with specialized knowledge or training in a particular field. The advice of a pathologist will help to determine whether the public interest dictates that an inquest should be held, in the same way that the advice of expert investigators and other circumstances will affect the decision. The discretion whether to hold an inquest involves a social question that is not within the exclusive province of medical personnel. Nor can recommendations to prevent deaths in the future be viewed as within the exclusive province of medical personnel. As one commentator has concluded:

> Now that a medical specialist is being engaged in most cases reported to coroners, the case for requiring the coroner to have medical skill dissolves. The present system appears to work efficiently . . . It would obviously be inappropriate to have the pathologist himself functioning

> as coroner, because, where the inquest is held, the pathologist is an essential witness. It would be equally inappropriate to have one doctor presiding as coroner in order to question a second doctor who is giving evidence as a pathologist.[56]

Basic to the coroner's system is the principle that the coroner has the discretion to hold an inquest if he feels it will serve a useful purpose. A medical examiner does not have that power, although he may usually recommend that an inquiry be held. Two advantages of the coroner's system are the appearance of independence and the public involvement that comes from vesting in the coroner the power to hold an inquest with a jury without the permission of government or police authorities. When the facts need to be aired, they are most effectively aired before a group of men and women in the community where the death occurred. When a decision has to be made as to whether the facts will come out in public, that decision ought to be made by an official with the appearance of independence. If the investigation system is to serve the purpose of ensuring the public that deaths of fellow citizens will be adequately investigated, the elements of independence and public involvement ought to be retained.

III. A PROPOSED SYSTEM FOR SASKATCHEWAN

1. Officers of the System

(a) Coroners

(i) Qualifications, Disqualifications

There are currently 164 coroners in Saskatchewan, of whom 54 possess medical qualifications. A large number are retired police officers with investigative expertise. None are lawyers. Among those Canadian jurisdictions which employ the coroner system, only Ontario requires that new coroners must be qualified medical practitioners.[57] Since the Commission is of the opinion that coroners should rely on persons with specialized knowledge in the exercise of their duties, it is neither necessary nor particularly desirable to restrict the office of coroner to persons with specialized knowledge or training in a particular field. The Commission is of the view that the system can most effectively serve its purpose through the involvement of a wide variety of persons with the particular expertise required by the case at hand. Common sense, demonstrated competence and integrity are the most vital qualifications of persons holding the office of coroner.

Section 3 of *The Coroners Act* sets out circumstances in which it would not be appropriate for a coroner to conduct an investigation or an inquest. These are:

> (a) where the coroner has attended upon the deceased as a physician within 30 days prior to death;
>
> (b) where the coroner has performed an autopsy or post-mortem examination;
>
> (c) where death was caused at a "work" owned wholly or partially by the coroner or a company of which he is a shareholder, or with respect to which he is employed in any capacity by the owner or the employees.

These disqualifications are sensible, but some expansion is warranted. The 30 day period should be greatly expanded. The coroner should not act if he, or a partner, associate, employee or employer, has administered treatment to the deceased six months prior to the death. Nor

should the coroner act if his conduct, or the conduct of a partner, associate, employee or employer or of a hospital of which he is a member of the medical staff, might be called into question.

(ii) Appointment

Subsection 2(1) of *The Coroners Act* provides that the Lieutenant Governor in Council may appoint coroners. This has always been the method of appointment of coroners in Saskatchewan. In 1978, however, the *Act* was amended to provide for the office of chief coroner who is responsible for the proper administration of the *Act*, and is to "supervise and direct all coroners in the performance of their duties".[58] The chief coroner will have considerable experience in the coroner system, and be familiar with the demands placed upon coroners and the skills best suited to the job. It would seem appropriate, therefore, to provide in the *Act* that the chief coroner make recommendations to the Lieutenant Governor in Council respecting the need for appointment of new or additional coroners. This is in fact done in practice.

Under common law, when the Lieutenant Governor in Council has made appointments by order-in-council, the appointee holds office during pleasure, and the order-in-council can be revoked at any time.[59] It would be useful to make some provision for termination of appointments of coroners. Provision should also be made to permit a coroner to resign his office in writing. In view of the fact that the chief coroner is responsible for the proper administration of the *Act* and supervises coroners on a daily basis, the chief coroner should be authorized to recommend the suspension or removal of any coroner for misconduct, neglect of duty, or inability to perform his duties.

(iii) The Number of Coroners

In order to ensure that coroners are able to gain sufficient experience to carry out their functions effectively, it is desirable to keep the number of coroners as low as possible while retaining coroners throughout the province. The number of coroners in Saskatchewan has been dramatically reduced over the years, and the chief coroner endeavours to keep the number as low as possible. This is difficult to achieve because of the geography of the province. Many coroners cover vast areas but are not called upon to conduct a large number of investigations. In England, it has been recommended that a full-time coroner should handle some 1,500 cases per year, while a part-time coroner should handle 500.[60] In Saskatchewan, however, there are approximately 1,800 investigations in total per year.

The caseload in Saskatchewan is small enough that one or two full-time coroners located in the larger centres could handle all cases. But even in Ontario, there are only a handful of full-time coroners, and those are employed only in densely-populated metropolitan centres such as Toronto.[61] In both provinces, geography dictates a larger number of coroners than the caseload itself justifies.

The legislation should not attempt to weigh the factors which will determine the optimum number of coroners. That should be left to the chief coroner as advisor to the Lieutenant Governor in Council.

(b) The Chief Coroner

Until 1978, no official mechanism existed to supervise the operation of the coroner system in Saskatchewan. In that year, the office of chief coroner was created by amendment to *The Coroners Act*, and the Coroners Branch was established in the Department of the Attorney General. The office has been filled by a medical practitioner on a part-time basis since its establishment.

The role of the chief coroner is set out in subsection 2(3) of the *Act*. He is directed to:

(a) be responsible for the proper administration of this Act;

(b) supervise and direct all coroners in the performance of their duties;

(c) establish and conduct programs for the instruction of coroners in their duties;

(d) bring any findings and recommendations of coroners and jurors to the attention of appropriate persons, agencies, departments or ministries of government;

(e) perform any other duties that are assigned to him by this Act or the regulations, by any other Act or by the Attorney General.

For the most part, the Commission feels that the legislation adequately sets out the role of the chief coroner, but several duties, some of which are now performed by the chief coroner in practice, should be included in the legislation.

One of the prime objectives of the coroner system is public safety. The need for change in industrial practices, construction standards or health regulations also becomes apparent from a review of coroners' reports and the recommendations of coroners' juries from across the province. The Commission is of the view that there ought to be an effective public watchdog. The chief coroner is required to bring jurors' recommendations and coroners' findings to the attention of "appropriate persons, agencies, departments or ministries of government", but he has no mandate under the *Act* to pursue the public interest further. If the chief coroner as "public watchdog" is to play a meaningful and effective role, the public has a right to hear what he has to say. The chief coroner should be empowered to bring the need for change arising out of coroners' findings or juries' recommendations to public attention. He should be able to do so without fear that he can be summarily removed from office for doing so when he has made a legitimate and reasoned criticism of government inaction. The freedom of the chief coroner to speak is important not only in preventing deaths, but also in maintaining public confidence in the integrity of the death investigation system.

The chief coroner should have the power to make public reports where it is in the public interest to do so. In cases where a pattern of deaths persists, or where recommendations have been made but are ignored, it would be in the public interest for the chief coroner to make a statement on the matter.

When citizens are improperly treated by government bureaucracy, they have a champion in the province's Ombudsman.[62] He may make recommendations to the government when wrong has been done and correction is in order. When his recommendations are not acted upon, he may report the fact to the Attorney General and he may also issue public reports on particular matters. The coroner has been described as the "ombudsman for the dead". This is an apt description. The system serves to ascertain whether the deceased could have been better treated. But the coroner is also an ombudsman for the living; his work will prevent similar deaths. Just as the Ombudsman has the right to bring injustices to the attention of legislators and the public, so too should the chief coroner be allowed to bring unsafe conditions to public light where matters of life and death are at stake.

The Ontario Law Reform Commission[63] has recommended statutory recognition of some other responsibilities of the chief coroner's office that would strengthen its role. It has proposed that the chief coroner have a responsibility "to assist coroners in obtaining medical and other experts where necessary". The coroner system must be founded upon access to expert advice and opinion. To facilitate access to the assistance of medical doctors, forensic scientists

and specialists in industrial processes or public safety, the Ontario Law Reform Commission has suggested that the chief coroner should maintain liaison with the professional groups coroners must draw upon.

It has also proposed that the chief coroner "prepare, publish and distribute a code of ethics for coroners". In the operation of the coroner system, a variety of circumstances may arise where coroners are faced with questions relating to their proper conduct. There may be some situations where it would not appear proper for a coroner to take charge of a particular investigation or inquest, although the situation would not be specifically addressed by the disqualification provisions of the *Act*. For example, a coroner may have had some personal connection with the deceased, his relatives or associates, or someone directly or indirectly involved in the circumstances of the death. In addition, a policy respecting public pronouncements by coroners concerning investigations or inquests might be useful. These and other matters can be addressed in a code of ethics prepared by the chief coroner.

The office of chief coroner was created in order to introduce a professional administrator with experience and expertise into the coroner system. As the Ontario Commission suggested, in the day-to-day operation of the system "[c]oroners should report to the chief executive officer of the coroner system, and that officer should bear the responsibility for informing the Minister of any matter that may require his attention or decision".[64] Coroners should not continue to report to the Attorney General. Yet, section 6 and subsection 7(1) of the *Act* require coroners to report the result of their investigation and their decision as to whether or not an inquest should be held to the Attorney General. Subsection 20(3) requires a coroner, at the conclusion of an inquest, to forward to the Department of the Attorney General, *inter alia*, the jury verdict and a transcript of the evidence. Subsection 21(2) requires a coroner to submit the evidence taken at an inquest, together with such facts upon which the jury has agreed, to the Attorney General where the jury has been unable to agree upon a verdict. These matters ought to be reported to the office of the chief coroner for his consideration.

Several sections of the *Act* confer discretion upon the Attorney General. Subsection 5(2) enables the Attorney General to instruct a second coroner to take over an investigation or an inquest. This may be necessary where a coroner has already issued his warrant to take possession of the body before he realizes that it would be inappropriate for him to act. That discretion should be exercised by the chief coroner.

The Attorney General is also empowered to:

1. direct that an inquest be held notwithstanding that the investigating coroner decided that an inquest was unnecessary[65];
2. order an inquest in any case where he believes it advisable[66];
3. waive exhumation of a body prior to an inquest where it is known to the coroner that no good purpose will be affected by exhuming the body[67];
4. consent to the taking of evidence by a stenographer and ordering it to be transcribed[68];
5. direct a second inquest to be held or some other action taken where the jury is unable to agree upon a verdict at an inquest[69];
6. order a post-mortem or other examination of a body and disinterment if necessary[70].

As the chief administrative officer of the coroner system, the chief coroner should be empowered to make those decisions which may be necessary in the operation of the system. It would, therefore, be appropriate to allow both the chief coroner and the Attorney General to make decisions under the above provisions. In most instances, the Attorney General would have no interest in personally exercising his discretion under *The Coroners Act*.

2. Reporting Deaths

(a) The Need for Reporting

One of the most crucial aspects of an effective coroner system is the mechanism for reporting deaths to the coroner. Originally, all cases of sudden death, from whatever cause, were reported. Later, only cases where there was manifest evidence of violence were scrutinized.[71] The categories of reportable deaths are now broad, but vaguely defined.

Legislation must ensure that those deaths which ought to be investigated are brought to the coroner's attention, but prescription of classes of death which must be reported should not create inordinate delay and needless intermeddling. Traditionally, in every case where a death was reported to a coroner, a jury had to be summoned to view the body and an inquest had to be held. Under modern coroner legislation, notification to the coroner simply means that he examines the situation. No inquest is necessary unless the coroner is of the opinion that it would serve a useful purpose. The jury need not view the body. Thus, unless there are unanswered questions or matters which must be aired in public, notification simply means that the coroner shall investigate the death himself or with the assistance of medical or other investigative personnel.

To ensure that deaths which should be investigated are in fact reported, the coroner system must work in tandem with the death registration system. *The Vital Statistics Act*[72] requires that a death must be registered before a permit can be issued for disposal of the body. This ensures that no body is disposed of before the circumstances of the death are examined, when necessary, by the coroner. *The Vital Statistics Act*, therefore, must dovetail with *The Coroners Act*. The former *Act* must operate so that where a death should be reported under *The Coroners Act*, no burial permit will be issued under *The Vital Statistics Act* until the coroner has had an opportunity to make his investigation.

Until the nineteenth century, no formal system for registration of death as a prerequisite to disposal of bodies existed. The enactment of the English *Births and Deaths Registration Act, 1836*[73] resulted in more cases being brought to the coroner's attention and increased recognition of concealed homicide than in the past.[74]

In the vast majority of deaths, the coroner is not notified. A physician certifies the medical cause of death pursuant to *The Vital Statistics Act*, the death is registered and a burial permit issued. When the cause of death is not certified by a medical practitioner or the death is one which must be reported under *The Coroners Act* notwithstanding certification of the cause of death, the registration of the death is delayed until the coroner has determined the cause of death or completed his investigation. Burial may be allowed in the interim under clause 18(2)(a) of *The Vital Statistics Act* if the coroner has not completed an investigation.

(b) Specific Categories of Death Which Must be Reported

Subsection 4(1) of *The Coroners Act* provides that "every medical practitioner, funeral director, embalmer or other person" who has reason to believe that a death has occurred:

1. as a result of violence or misadventure,
2. by unfair means,

3. from a cause other than disease or sickness,
4. as a result of negligence or misconduct or malpractice on the part of others, or
5. under such circumstances as require investigation

is to "immediately notify" a coroner of the facts and circumstances relating to the death. It is an offence to fail to do so.

Some deaths which are not now expressly reportable are reported under the catch-all category of deaths "under such circumstances as require investigation". However, it appears that not all deaths which deserve investigation are reported by all physicians. In practice, there is considerable variation in reporting practices of physicians. Statistics collected by the chief coroner indicate that as few as 13% of deaths are investigated in some communities, while in others as many as 87% of deaths are investigated by the coroner. The circumstances which require an investigation of a death should be clarified by stipulated additional categories of reportable deaths, and deleting the vague catch-all category.

The following categories of death should be expressly reportable:

1. sudden, unexpected deaths;
2. suicides;
3. deaths occurring without medical attendance;
4. deaths during or shortly after surgery;
5. deaths related to employment practices or conditions;
6. undisclosed deaths;
7. deaths in institutions;
8. stillbirths.

Sudden, Unexpected Deaths: At present, sudden, unexpected deaths which do not fall into a specific category are reported sporadically, depending primarily on the practices of particular physicians. Where a person has died suddenly and unexpectedly, the safest course would be to provide investigation as a matter of course. Such an approach would provide an effective screen to ensure that the circumstances are satisfactorily explained. Alberta now requires reporting of deaths which occur "unexpectedly when the deceased was in apparent good health", and other provinces make similar provisions.[75]

Suicides: Three provinces have expressly provided that cases of apparent suicide should be reported.[76] Such deaths should be scrutinized by the coroner.

Deaths Occurring Without Medical Attendance: Under subsection 14(3) of *The Vital Statistics Act*,[77] the medical practitioner "who was last in attendance during the last illness" of the deceased is to certify the cause of death. Clause 14(4)(a) provides that the coroner is to be notified where "a death occurs without medical attendance". The meaning of "last in attendance", "last illness" and "without medical attendance" is vague. Is "attendance" sufficient if the deceased was seen within a period of days, weeks or months prior to death? Without defining what is meant by attendance, there is no way of knowing, once the cause of death is certified, whether or not certification was based upon a presumption that a known ailment continued until death and caused the death. The cause of death may have in fact arisen shortly before death and subsequent to the last medical attendance. Under former forms[78] for registration of death under *The Vital Statistics Act*, the certifying physician indicated the period he attended the deceased and the date he last saw the deceased alive. Under the current form, however, the certifying physician is not required to do so.[79]

The form for registration of death should require the certifying physician to indicate the period within which he attended upon the deceased, the date upon which he last attended upon the deceased, and whether he examined the deceased subsequent to death.

The meaning of "medical attendance" should be clarified so that there can be no doubt that certification is based upon attendance proximate in time to the date of death, and not upon assumptions made from clinical history. When there is not sufficient medical attendance, the coroner should be involved to ensure that the cause of death is accurately determined.

In England, the registrars of death have been required to report deaths to coroners if the certifying physician did not see the deceased within 14 days prior to death, or "during his last illness" where it is known the illness arose within a period shorter than 14 days prior to death.[80] British Columbia has prescribed that deaths which occur "from disease, sickness or unknown cause for which [the deceased] was not treated by a medical practitioner" should be reported to the coroner.[81] The Alberta legislation provides for the reporting of "deaths that occur while the deceased person was not under the care of a physician".[82] The English provision is preferable, since it provides some guidance respecting the sort of medical attendance which is sufficient basis for certification.

While deaths occurring without medical attendance should be reported to the coroner, he may satisfy himself that in the circumstances it is not necessary for him to take possession of the body or conduct any further investigation. Such would be the case, for example, where the physician certifying the cause of death conducted an autopsy and determined the cause of death in that manner. The form for registration of death indicates whether or not an autopsy is being held.[83] Similarly, subsection 5(3) of *The Coroners Act* provides:

> When a coroner is notified by a funeral director under *The Vital Statistics Act* of a death occurring without the attendance of a duly qualified medical practitioner, it shall not be necessary for the coroner to issue his warrant to take possession of or view the body if the coroner, after inquiry into all the circumstances connected with the death, is satisfied that death occurred from natural causes and deems it unnecessary to hold an inquest.

Such a provision is consistent with the purposes of the reporting system.

Deaths During or Shortly After Surgery: This category of death should routinely be reported to the coroner for verification of cause. To leave discretion to the medical personnel involved in the surgery to decide whether there are circumstances warranting investigation places them in a difficult position. Reporting the death may imply negligence on their part. A mandatory requirement to report would remove any ground for suspicion of concealed negligence. Alberta provides for the reporting of "deaths that occur within 10 days of an operative procedure or while under anesthesia or during recovery from anesthesia".[84]

Deaths Related to Employment Practices or Conditions: In the interests of industrial safety, deaths occurring in the course of employment should be reported to enable the coroner to assess whether or not employment practices or conditions are safe. Alberta requires reporting of:

> deaths that are due to
>
> (i) any disease or ill-health contracted or incurred by the deceased,
>
> (ii) any injury sustained by the deceased, or

(iii) any toxic substance introduced into the deceased,

as a direct result of the deceased's employment or occupation or in the course of one or more of his former employments or occupations.[85]

Undisclosed Deaths: To ensure that all deaths are properly registered, and investigated if necessary, a duty to report should be imposed on persons who know a death has occurred where the body has not been discovered or properly dealt with, or the death has not been properly registered. The Alberta Legislation provides that:

> If a person knows or believes that a death has occurred in Alberta but no body has been located because
>
> (a) the body or part of the body has been destroyed,
>
> (b) the body is lying in a place from which it cannot be recovered, or
>
> (c) the body has been removed from Alberta,
>
> that person shall immediately notify a medical examiner or a member of the Royal Canadian Mounted Police or a member of a municipal police force.[86]

Deaths in Institutions: Society has an interest in ensuring that persons who are involuntarily in the care or custody of others are not mistreated. Deaths in certain institution settings should, therefore, be reported to a coroner on a routine basis. The present *Coroner Act*[87] deals only with prisoners in jails, penitentiaries, lock-ups, or correctional facilities. There are deaths in other types of institutions that many physicians believe should be brought to the attention of coroners. These are now reported by some physicians, but not on a uniform basis. Institutional deaths of such persons should be reported to ensure that no mistreatment or neglect has contributed to the death. Deaths of such persons, by their very nature, warrant scrutiny. The following categories of deaths ought to be reported:

1. deaths of prisoners in jails or detention centres;
2. deaths of persons detained by or in the custody of a peace officer;
3. deaths of patients in mental institutions;
4. deaths of children in institutions for the care of children or while under the care of the Department of Social Services.

Several Canadian jurisdictions require reporting of all or some of the categories enumerated above.[88]

Section 47 of *The Mental Health Act* provides that:

> If a person dies while detained in an in-patient facility, the medical officer in charge may, if he deems it advisable that a post-mortem examination should be made, appoint a pathologist or any other competent person to make such examination and certify the cause of death.[89]

It is inappropriate for the administrator of the institution to decide what investigation is warranted. That decision should be made by the coroner upon report of the death. Section 47 of *The Mental Health Act* should be repealed.

Stillbirths: The coroner's jurisdiction when a stillbirth has occurred is not clear. Technically, a stillbirth may not be a death within the meaning of the *Act*. Registration of stillbirths is, however, required under section 9 of *The Vital Statistics Act*.

Questions relating to the reporting of stillbirths most often arise when no physician was in attendance at the stillbirth. Many physicians do notify the coroner in such cases, but the practice is not universal. Certainly, investigation would be warranted in those cases, but in addition, the coroner should investigate stillbirths in any case in which investigation would have been warranted had the death occurred after birth. *The Coroners Act* should provide for the reporting of stillbirths without medical attendance, and should provide that stillbirths are to be regarded as deaths for the purposes of the *Act*.

(c) Disposal, Alteration and Removal of Bodies

Cremation and removal of bodies from Saskatchewan make investigation impossible. It is therefore necessary to regulate these matters. They are not now explicitly dealt with in *The Coroners Act* or *The Vital Statistics Act*.

Embalming: Because embalming renders certain tests that may be necessary to determine the chemical or alcoholic content of a body impossible, it must not be carried out until the cause of death is determined. *The Coroners Act* should provide that when a death is one which must be reported to a coroner, the state of the body shall not be altered in any fashion, externally or internally, without authorization by the coroner. Several jurisdictions now have provisions to that effect.[90]

Autopsies: Because an autopsy may interfere with the ability of medical investigators to carry out necessary procedures and analyses, *The Coroners Act* should provide that when a death is reportable, no autopsy shall be carried out in cases of death which should be reported to a coroner under the *Act* until authorized by a coroner. The recommendation made in regard to regulation of embalming is sufficiently broad to prevent a premature autopsy.

Cremation: Despite efforts to adequately record the cause of death prior to disposition of bodies, cases occur where suspicion arises or new facts come to light after disposal of a body. Bodies are occasionally disinterred to allow further investigation, but this is not possible after cremation. No permit for disposal of a body by cremation should be issued without the coroner's permission. Alberta presently provides some regulation of cremation.[91]

Cremation also raises an additional problem. Some bodies may contain a sealed, long-lived radio nuclide pacemaker which, when incinerated may explode and cause extensive damage and personal injury. A coroner should not permit cremation in any case in which the body has not been examined, and such device removed.

Bodies Removed from Saskatchewan: Presently, coroners need not be notified when a body is removed from the province. A coroner's approval for removal of a body from Saskatchewan should be required. Several provinces now have such a requirement.[92]

Bodies Brought into Saskatchewan: At present there is no requirement that Saskatchewan's registration or reporting procedures be complied with when a body is brought into Saskatchewan for disposition if the burial permit or equivalent document "prescribed under the law of the province or country in which the death occurs"[93] has been obtained. A burial permit issued by the jurisdiction in which death occurred, however, may have been issued on the basis of certification and investigative procedures less stringent than those in Saskatchewan. A coroner should be required to ensure that the cause of death has been certified in a manner acceptable in this province prior to disposition of the body. It is recommended, therefore, that where a body is brought into Saskatchewan for disposition, a burial or cremation certificate should be obtained from a coroner. Alberta now has a similar provision.[94]

3. Registration of Deaths under *The Vital Statistics Act* and the Coroner System

The Commission has been informed that the Vital Statistics Division of the Department of Health is in the process of reviewing *The Vital Statistics Act*. The Commision has consulted with the Division regarding the relationship between the provisions of *The Vital Statistics Act* relating to registration of death and *The Coroners Act*.

The Commission's proposed *Coroners Act* has been drafted to permit its implementation prior to amendment of *The Vital Statistics Act*. However, the amendments being considered by the Division would simplify registration of deaths in cases in which a coroners investigation is required, and provide additional safeguards to ensure proper scrutiny of deaths. The recommendations for amendment of *The Vital Statistics Act* in this report reflect the Commission's discussions with the Division. (See Appendix "Revision of *The Vital Statistics Act*").

The Division proposes that coroners should serve as registrars of death. This means that every certificate of death will be examined by a coroner (in the capacity of registrar). Because there are many categories of death that must be reported, it is possible that persons who are charged with a duty to report deaths to a coroner will forget or neglect to do so. Having coroners act as registrars of death will go far in ensuring that reportable deaths are brought to the attention of a coroner.

The form for the registration of deaths should set forth the classes of deaths that are to be reported. This would direct the certifying physician to consider whether the death falls into any of these categories.

The certificate of death should indicate whether or not the death occurred in a hospital or special care home. Although some deaths in institutions must be investigated by the coroner under the proposed *Coroners Act*, it would not be desirable to extend that policy to hospitals or special care homes. Nevertheless, it would be useful to require some sort of notification in such cases This would, for example, permit statistics to be compiled which might reveal unusual patterns of deaths, or unsafe practices.

Where the death is not reportable, and if the medical practitioner cannot immediately determine the cause of death, he should state on the death certificate "cause of death not immediately ascertainable — death not reportable to coroner". The fully completed certificate would then be filed with the registrar within fourteen days of the death.

The coroner should be permitted to release the body for burial prior to determining the cause of death by completing the death certificate and entering in place of the cause of death the words "This body released for burial". The fully completed certificate would then be filed with the Director of Vital Statistics within two days of determining the cause of death, or completion of the investigation or inquest.

Where a death is not reportable but has occurred at the deceased's home, the attending physician or a physician attending after the death must complete the certificate of death and leave it with the funeral director. Otherwise, the coroner must be notified.

Finally, no body should be buried in the province without a burial permit issued by the registrar.

4. Investigation

(a) Powers of Coroner

At present, *The Coroners Act*[95] directs the coroner, upon being advised of a death, to view the body, take possession of it and "make such further inquiry as may be required to satisfy himself whether or not an inquest is necessary". With the single exception of subsection

13(1), the *Act* does not expressly state the powers which the coroner has in conducting his inquiry. Subsection 13(1) of the *Act* provides:

> Where a coroner has ordered an inquest upon the body of a person who has met death by violence in the wreck of a building, bridge, structure, embankment, aeroplane, motor vehicle, boat, machine or apparatus, the coroner may take charge of all wreckage and place a constable in charge thereof so as to prevent persons from disturbing the wreckage until the coroner has made such examination as he deems necessary.

The coroner may, however, look to paragraph 2 of section 17 of *The Interpretation Act*[96] for some guidance. It provides:

> where power is given to the Lieutenant Governor in Council or a public officer to do or enforce the doing of any act or thing, all such powers shall be deemed to be also given as are necessary to enable him to do or enforce the doing of the act or thing;

Interpreted literally, that provision would give coroners powers potentially too broad. *The Coroners Act* should expressly set out those powers required by a coroner to properly investigate deaths.

The coroner's mandate to carry out his investigations should include power to:

1. take possession of and view a body;
2. enter and inspect any place where a dead body is believed to be or to have been;
3. enter and inspect any place where the deceased is believed to have been within a reasonable period of time prior to death;
4. secure the scene or area where death is believed to have occurred to enable investigation to be carried out;
5. upon a warrant issued by a judge of the Court of Queen's Bench enter any place to inspect documents, records, writings, objects or things which may directly relate to the circumstances of death, and reproduce and retain copies of, or take possession of, such documents, records, writings, objects or things;
6. request disinterment of a body where necessary;
7. direct post-mortem examination of the body.

Note that the coroner had power at common law to order disinterment.[97] If the common law with respect to coroners is repealed, this power must be included in the *Act*. The power to disinter should not be exercised without notice to the relatives of the deceased and to the owner of the cemetery.

The British Columbia and Ontario statutes set out the powers of coroners to carry out their investigation in a clear and fairly comprehensive manner.[98] The British Columbia section, which is almost identical to that of Ontario, provides as follows:

> (1) A coroner, or a medical practitioner or a peace officer authorized by a coroner to exercise all or any of his powers under this subsection, may
>
> (a) view or take take possession of any dead body, or both; and

(b) enter and inspect any place where a dead body is and any place from which the coroner has reasonable grounds for believing the body was removed.

(2) A coroner, where he believes on reasonable grounds that it is necessary to do so for the purposes of the investigation, may

(a) inspect any place in which the deceased person was, or in which the coroner has reasonable grounds to believe the deceased person was, within a reasonable time prior to his death;

(b) inspect information in any records relating to the deceased or his circumstances;

(c) seize anything that the coroner has reasonable grounds to believe is material to the investigation.

(3) The coroner may, where in his opinion it is necessary for the purposes of the investigation, authorize a medical practitioner or a peace officer to exercise all or any of his powers under subsection (2) but, where the power is conditional on the belief of the coroner, the belief must be that of the coroner personally.

(4) Where anything is seized under subsection (2)(c), the coroner shall keep it in safe custody and shall return it to the person from whom it was seized as soon as is practicable after the conclusion of the investigation or, where there is an inquest, after the conclusion of the inquest, unless he is authorized or required by law to dispose of it otherwise.

Both statutes grant the coroner a general power to order such post-mortem examination as may be necessary. Subsection 28(1) of the Ontario *Act* provides as follows:

> A coroner may at any time during an investigation or inquest issue his warrant for a *post mortem* examination of the body, an analysis of the blood, urine or contents of the stomach and intestines, or such other examination or analysis as the circumstances warrant.

A similar formulation of the powers of coroners should be adopted in Saskatchewan. However, the power to enter premises and remove objects or documents under section 16(2) of the British Columbia *Act* should not be exercised without a search warrant. Search and seizure without warrant is objectionable, and may in fact contravene the *Canadian Charter of Rights and Freedoms*.[99] The proposed *Act* requires the warrant to be obtained from a judge of the Court of Queen's Bench.

(b) Employment of Investigative Expertise and Medical Personnel

Under a coroner system the independent officer in charge of the investigation must retain the services of experts in various fields to assist in particular investigations, rather than rely exclusively on his own expertise.

To survey and adequately record the scene of death, the best expertise is available from police authorities. It is standard practice in Saskatchewan for the police to assist coroners in carrying out their investigations. This practice should be formalized, as it has been in some other jurisdictions,[100] by providing expressly that the coroner may delegate investigative functions to the police, and requiring the police force having jurisdiction in the municipality where the death occurred to assist the coroner.

In examining the medical circumstances of a death, the coroner now draws on the assistance of medical personnel. This practice should be formalized by expressly providing that the coroner has the authority to delegate investigative powers to experts other than the police.

Reliance upon medical personnel in coroners' investigations is extensive. Of the approximately 1,800 cases reported to coroners annually, about 1,300 autopsies are performed. In the majority of cases, it is extremely difficult to accurately determine the cause of death without an autopsy. Numerous studies have shown that the margin of error in clinical diagnosis is high where only an external examination of the body is conducted.[101] Of the 1,300 autopsies performed at the behest of coroners in Saskatchewan each year, less than 100 are performed by general practitioners. It is generally conceded that autopsies should be performed by qualified pathologists. Alberta's *Fatality Inquiries Act* requires autopsies to be performed by pathologists.[102] The chief coroner for Saskatchewan is of the view that to restrict the performance of autopsies to qualified pathologists would not cause serious problems in Saskatchewan. The *Act* should provide that autopsies for the purpose of a coroner's investigation should only be carried out by pathologists and that the chief coroner should determine the precise qualifications of pathologists.

It may also be necessary in the course of the coroner's investigation for the coroner to employ non-medical experts. For example, a structural collapse which resulted in death would almost certainly warrant the retaining of engineering consultants.

Subsection (1) of section 5 of *The Coroners Act* provides that upon being advised of a death, the coroner shall "view the body". At common law, his jurisdiction was actually dependent upon the act of viewing the body. The requirement stems from ancient times, when the state of medical knowledge was not far advanced, and the only medical evidence relied upon by coroners and their jurors was their external examination of the body and their own assessment of injuries.[103] The viewing of the body is no longer necessary today. It makes no sense to require a coroner who is not medically trained to examine the body. Even if the coroner is a medical practitioner, he may decide to rely on an examination by a qualified pathologist. The requirement that the coroner view the body should be abolished.

(c) Publicity

The inquest provides a mechanism for making public the facts of a death where it is desirable to do so. But coroners must be careful during the course of preliminary investigations to restrict their public statements to factual matters, and to avoid speculation about the conduct of the deceased or those directly or indirectly connected with the death. As the Ontario Law Reform Commission noted:

> Regardless of the nature of the circumstances, however, it cannot be over-emphasized that, in his capacity as an investigator, the coroner's task is to ascertain facts and not to pass judgment upon the activities of those whose behaviour is thereby called into question. For an investigating coroner publicly to give voice to his conclusions as to the propriety of the conduct of the principals involved in a case, regardless of the nature of the facts involved, would be a denial of due process of law to anyone whose reputation, ability, professional standing or judgment is thereby affected or impugned.[104]

The Ontario Commission also recommended that rules respecting public statements by coroners should be set down in a code of ethics for coroners prepared by the chief coroner. Such rules should not, however, prevent coroners from advocating necessary changes in the law, regulations and safety codes.

Where no inquest is held, the question arises as to what information gathered by the coroner should be available for public inspection. The Commission is of the view that one of the most important purposes of the coroner system is to maintain an open and public system of death investigation. Factual information should be readily available to the public. Personal opinion, allegation and speculation should not, however, be available for public inspection.

The Ontario Commission recommended that when the results of a coroner's investigation are filed, the report or file should be comprised of two parts, and the part containing factual information should be a public record. That approach is viable.

5. Inquest

(a) Public Nature, Exceptions

Inquests into deaths should be open to the public. It has been said that:

> It is a basic tenet of western democratic thought that public confidence in authority is possible only if all facets of government are subject to public scrutiny. One role of the modern inquest is to ensure that the various agencies responsible for the enforcement of criminal law are acting with diligence.[105]

There are, however, circumstances in which other interests should prevail.

Under the common law, an inquest could be held *in camera* at the discretion of the coroner, where privacy was deemed necessary for the sake of decency or out of respect for the family of the deceased,[106] but *The Coroners Act* makes no explicit provision in this regard. Some jurisdictions grant a broad power to coroners to ban publication or broadcast of evidence taken at the hearing[107] or to hold the hearing *in camera*,[108] without providing guidance as to the circumstances in which the proceeding should not be public. Such provisions are too broad. The Ontario Law Reform Commission[109] and the *Ontario Royal Commission Inquiry into Civil Rights*[110] recomended that inquests be public except where matters of national security were involved. When Ontario's new *Coroners Act* was drafted, however, the legislature also provided that an inquest could be held *in camera* where a person was charged with an indictable offence in connection with the death.[111] British Colombia has done likewise.[112]

In the Commission's opinion, a number of situations exist where it may be advisable to exclude the public.

(i) Exclusion of Witnesses

The power to exclude witnesses is necessary to ensure that evidence given by some witnesses is not influenced by the testimony of earlier witnesses.

(ii) National Security

While matters of national security are unlikely to arise very often at coroners' inquests, there should be power to exclude the public and ban publication when such matters do arise.

(iii) Suicide

Where a death is found to be a suicide, if the public interest does not demand the release of details, needless embarrassment and "copy-cat" suicides should be avoided by a ban on publication or broadcast of the evidence. It is not necessary that the inquiry proceed *in camera* in such cases. An alternative is the approach taken in New Zealand, where the coroner may restrict publication of evidence relating to the details of suicides to the basic statement that a death was found to have been self-inflicted.[113]

(iv) Criminal Cases

Inquests are not usually held where a person has been charged with a criminal offence arising out of the death. The *Canadian Charter of Rights and Freedoms* guarantees a person the right to a fair hearing,[114] and the *Criminal Code* bans publication of evidence. Therefore, a ban on publication in such cases would be appropriate. The Attorney General may, however, direct an inquest in such a case. In addition, there may be cases where it does not become apparent that a person will be charged with a criminal offence until the inquest is actually underway. A coroner's inquest should not expose a person who is to undergo trial after the inquest to adverse publicity which may seriously prejudice his chances of obtaining a fair trial.

(b) Compulsory Inquest

In general, a decision to hold an inquest should be made by the coroner. He will bring his experience to bear in determining whether an inquest should be held.

Subsection (2) of section 9 of *The Coroners Act* presently requires that an inquest be held whenever a death occurs in prison. The Commission does not recommend that inquests be made compulsory to any further extent. Deaths in other institutions where persons have been deprived of their liberty or are dependent upon others due to age or mental infirmity should be reported to a coroner, but most deaths so reported will be due to natural causes. Public confidence will be maintained by the knowledge that such deaths are scrutinized.

(c) Jury

The crucial role of the coroner in maintaining public confidence in the security of our society's members has been stressed throughout this report. The coroner's jury offers a means for public involvement in the system.

As one coroner stated in summation to his jury:

> The great value to my mind of the common law institution of the coroner is in you, the jury. In the jury are six independent members of the public at large. The people have a powerful overseer, an independent observer and a potent voice in the jury. The jury can look into and pronounce publicly upon the activities of every institution, body and individual in our society — when these bear upon the safety and welfare of one of its members. The power and thrust of the coroner's system is in the institution of the jury. No one is immune to their scrutiny. They can expose the shoddy tactics of powerful individuals, great corporations and the malfeasance and neglect of government and crown alike. The alternative to jury scrutiny of suspicious death is investigation by some agency of the very government or body that may in the public interest require scrutiny. In my opinion this is a most unsatisfactory alternative.[115]

Juries are not part of the medical examiner system, even in jurisdictions in which the examiner may recommend a public inquiry. In the Commission's opinion, this is one of the drawbacks of that system. The coroner's jury ought to be retained.

6. Inquest Procedure: General

(a) Coroner's Discretion Whether to Hold an Inquest

In order to maintain confidence in the integrity of the coroner system, a relative or other interested person should be able to question a coroner's decision not to hold an inquest. The Ontario *Coroners Act* provides that:[116]

26(1) Where the coroner determines that an inquest is unnecessary, the spouse, parent, child, brother, sister, or personal representative of the deceased person may request the coroner in writing to hold an inquest, and the coroner shall give the person requesting the inquest an opportunity to state his reasons, either personally, by his agent or in writing, and the coroner shall advise the person in writing within 60 days of the receipt of the request of his final decision and where the decision is to not hold an inquest shall deliver his reasons therefor in writing.

(2) Where the final decision of a coroner under subsection (1) is to not hold an inquest, the person making the request may, within twenty days after the receipt of the decision of the coroner, request the Chief Coroner to review the decision and the Chief Coroner shall review the decision of the coroner after giving the person requesting the inquest an opportunity to state his reasons either personally, by his agent or in writing.

(3) Subject to section 22 [unless the Solicitor General orders an inquest], the decision of the Chief Coroner is final.

The practice in Ontario under section 26 has been described as follows:

> The Chief Coroner may overrule his local coroner for a variety of reasons, but this decision is generally based on a later public demand or outcry, or in the public interest, or on demand by the suspicious or disbelieving family. Or, in his role as a watchdog, the Chief Coroner may have a gut feeling on the matter and decide to clear up any element of doubt that may exist.[117]

Although the Ontario practice is a step in the right direction, the right to question the coroner's decision not to hold an inquest should not be restricted to close family members. There may be others who knew the deceased or were connected with the death and who feel that certain questions require answers.

(b) Jury Selection

The Coroners Act does not prescribe the method of selection of jurors. Section 14 simply provides that the coroner may issue his warrant to a constable to summon persons to serve as jurors.

The governing principle in jury selection for a coroner's inquest, as for judicial proceedings, should be random selection. The case of *The King* v. *Divine*[118] dealt with a situation where a coroner selected his jury from a number of regulars. It was held that this practice is "... quite contrary to the principle of the jury system; which is the determination of questions of fact by persons taken at haphazard from the general body of qualified persons."[119] Nevertheless, the present *Act* lends itself to pre-selection of jurors rather than random selection. In fact, it was the practice of some coroners in the past to regularly summon the same individuals to make up the jury.

Under *The Jury Act, 1981*[120] jurors are selected for judicial proceedings by sheriffs in accordance with rules designed to ensure random selection. A similar system should be adopted for selection of coroner's juries.

Section 15 of *The Coroners Act* disqualifies certain individuals from sitting as jurors at inquests in situations where an appearance of bias may arise. Subsection (1) disqualifies officers, employees or inmates of specified health and correctional institutions in which the

death which is the subject of the inquest has occurred. The scope of the subsection should be broadened to include all institutions in which persons are confined. Subsection (2) disqualifies owners or employees of owners of buildings or premises in which a death has occurred from serving on a jury at an inquest into the death of an owner or employee of a trade or business located in the premises. The disqualification should also apply to owners and employees of the trade or business.

While it is desirable to retain the specific cases of disqualification set out above, it is not possible to set out all of the circumstances in which persons should not serve as jurors because of the likelihood of bias. Where a person summoned for possible jury service stands in a position which creates a real likelihood of bias, the presiding officer should have a general power to disqualify him from jury service. A likelihood of bias may arise, for example, out of personal, professional or financial involvement with the deceased or his family. The Ontario *Act* provides:

> The coroner presiding at an inquest may exclude a person from being sworn as a juror where the coroner believes there is likelihood that the person, because of interest or bias, would be unable to render a verdict in accordance with the evidence.[121]

The Saskatchewan *Act* should so provide.

(c) Securing Attendance of Witnesses, Evidence

It is important to the operation of the coroner system that the coroner be clothed with sufficient power to command that all relevant evidence be brought forward. He should therefore be authorized to subpoena individuals to give evidence and produce relevant documents or articles at an inquest.

Subsections (6) and (7) of section 16 of *The Coroners Act* prescribe a procedure permitting the coroner to order the attendance of a witness confined to a correctional facility or a penitentiary. These should be retained.

With the repeal of the common law respecting coroners, the coroner should be specifically empowered to administer oaths and affirmations.

Under section 16(5) of *The Coroners Act*, a person summoned as a juror or witness who fails to appear or remain at an inquest, refuses to take an oath or make an affirmation, refuses to testify, or obstructs the conduct of the inquest may be fined or imprisoned. The subsection provides that the coroner:

> . . . may deal summarily with that person and, unless the person shows cause why he should not be fined or imprisoned, the coroner may impose a fine of not more than $200 or imprisonment for a period of not more than 90 days, or both such fine and imprisonment.

In addition, coroners possess the power to commit for contempt under the common law.[122]

The power to fine or imprison individuals is a weighty one. In some cases, non-attendance may be justified by reasonable excuse, and refusal to answer questions may be a justifiable response to a line of questioning which is irrelevant or vexatious. The decision to cite a person for contempt is a judicial one. It is not appropriate, therefore, for that decision to be made by coroners. As Ontario's *Royal Commission Inquiry into Civil Rights* concluded:

> We do not think the powers of the Supreme Court over the liberty of the subject should be exercised by others than judges. The right to commit to jail is not a power that should be given to a coroner.[123]

The coroner should, in the circumstances dealt with by subsection (5) of section 16 of the present *Act* be authorized to apply to a judge of the Court of Queen's Bench for an order of committal. The Ontario statute provides:

> Where any person without lawful excuse,
>
> (a) on being duly summoned as a witness or a juror at an inquest makes default in attending at the inquest; or
>
> (b) being in attendance as a witness at an inquest, refuses to take an oath or to make an affirmation legally required by the coroner to be taken or made, or to produce any document or thing in his power or control legally required by the coroner to be produced by him or to answer any question to which the coroner may legally require an answer; or
>
> (c) does any other thing that would, if the inquest had been a court of law having power to commit for contempt, have been contempt of that court,
>
> the coroner may state a case to the Divisional Court setting out the facts and that court may, on application on behalf of and in the name of the coroner, inquire into the matter and, after hearing any witness who may be produced against or on behalf of that person and after hearing any statement that may be offered in defence, punish or take steps for the punishment of that person in like manner as if he had been guilty of contempt of the court.[124]

In order to ensure that coroners are able to maintain order during the course of an inquest, coroners should be empowered to remove any person whose presence is disruptive. Ontario has provided that:

> A coroner may make such orders or give such directions at an inquest as he considers necessary for the maintenance of order at the inquest, and, if any person disobeys or fails to comply with any such order or direction, the coroner may call on the assistance of any peace officer to enforce the order or direction, and every peace officer so called upon shall take such action as is necessary to enforce the order or direction and may use such force as is reasonably required for that purpose.[125]

(d) Rules of Evidence

At present, there is no statutory direction concerning the type of evidence a coroner may receive. Adherence to the strict rules of evidence employed at judicial proceedings is not required by the common law at an inquest, since the verdict of the coroner's jury is not determinative of anyone's rights. A coroner can, therefore, admit hearsay or opinion evidence that would not be admitted in a judicial proceeding.[126]

If the common law respecting inquests is repealed, the rule governing admissibility of evidence should be set out in the statute. As a corollary to this general rule, the coroner should have the power, now expressed in subsection 17(7) of *The Coroners Act*, to disallow vexatious or irrelevant examination or cross-examination.

The British Columbia,[127] Alberta,[128] and Ontario[129] statutes contain virtually identical provisions respecting the admissibility of evidence which embody the general rule stated above. Section 44 of the Ontario *Act* provides:

(1) Subject to subsections (2) and (3), a coroner may admit as evidence at an inquest, whether or not admissible as evidence in court,

(a) any oral testimony; and

(b) any document or other thing,

relevant to the purposes of the inquest and may act on such evidence, but the coroner may exclude anything unduly repetitious or anything that he considers does not meet such standards of proof as are commonly relied on by reasonably prudent men in the conduct of their own affairs and the coroner may comment on the weight that ought to be given to any particular evidence.

(2) Nothing is admissable in evidence at an inquest,

(a) that would be inadmissible in a court by reason of any privilege under the law of evidence; or

(b) that is inadmissible by the statute under which the proceedings arise or any other statute.

(3) Nothing in subsection (1) overrides the provisions of any Act expressly limiting the extent to or purposes for which any oral testimony, documents or things may be admitted or used in evidence.

(4) Where the coroner is satisfied as to their authenticity, a copy of a document or other thing may be admitted as evidence at an inquest.

(5) Where a document has been filed in evidence at an inquest, the coroner may, or the person producing it or entitled to it may with the leave of the coroner, cause the document to be photocopied and the coroner may authorize the photocopy to be filed in evidence in the place of the document filed and release the document filed, or may furnish to the person producing it or the person entitled to it a photocopy of the document filed certified by the coroner.

The basic rule would enable the coroner to admit copies of medical or other reports and documents containing factual information. These could be read into the record and entered as exhibits, without the necessity of calling the individuals who prepared them. This, however, should be subject to the right of parties at the inquest to request the individual who made the report or prepared the document to be called for examination and cross-examination. The British Columbia statute, for example, contains a provision allowing the introduction of a medical report without the attendance of the medical practitioner who prepared it.[130]

To assist the jurors in arriving at their verdict, the right of jurors to ask questions at the inquest, a matter of practice under the common law, should also be given legislative expression.

(e) Scope of the Jury's Function

It is not the role of the coroner's jury to draw conclusions of law or make findings of legal responsibility respecting deaths. *The Coroners Act* should so provide. In addition, if a jury verdict contains findings of legal responsibility for a death, the *Act* should empower the coroner to impose a ban on publication or broadcast of such findings.

7. Procedural Rights at Inquests

(a) Right to Standing

Coroners are usually not legally trained. Therefore, the procedure to be followed at coroners' inquests should be explicitly prescribed whenever possible. In addition, certain procedural rights should be given clear recognition; interested parties should have the right to participate in the fact-finding process. Otherwise, an appearance of a "whitewash" may result.

Subsection (6) of section 17 of *The Coroners Act* provides that a person the coroner finds to be "substantially and directly" interested in an inquest may examine and cross-examine witnesses called at the inquest, and be represented by counsel. This provision is too narrow. There ought not to be a requirement that a person be "directly" interested before the right to participate in an inquest can be granted. It is difficult to say who may be interested in the inquest in a direct sense. The Ontario statute, like that of Saskatchewan, allows participation by persons who are "substantially and directly interested in the inquest".[131] The inadequacy of such a narrow formulation is demonstrated in the case of *Inmates Committee of the Prison for Women et al* v. *Dr. C.R. Meyer*.[132] In that case, the death of an inmate was the subject of an inquest. The inmates' committee, as well as individual inmates, were denied the right to participate in the inquest on the ground that they did not have a "direct" interest in it. An inmates' committee is just the sort of group that might well have some worthwhile evidence to lead at an inquest with respect to matters such as prison conditions, the availability of emergency medical assistance or the adequacy of supervision. Public groups with particular interests in a wide variety of matters might well contribute to the public scrutiny of conditions or practices in diverse areas.

It should be possible for the coroner to allow participation by anyone who has a real interest in the issues raised by the inquest. As one author has noted:

> Proper interest should be liberally interpreted. It would extend to relatives of the deceased person, employers, insurers, manufacturers of apparatus which may have failed and hospital or municipal authorities.[133]

The English rules allow participation by "properly interested" persons.[134] Similarly, *The Coroners Act* of New South Wales speaks of a person with "a sufficient interest in the subject matter of the inquest".[135] As long as the coroner is empowered to disallow examination and cross-examination which is vexatious, irrelevant or unnecessary, and to limit the scope of the inquest to the parameters of its stated purpose, there should be no need to fear that participation by parties with a real interest in the proceedings will lead to unduly protected inquests.

In arriving at its verdict, the jury should be presented with relevant evidence and submissions from alternate points of view, not simply the evidence and submissions presented by the coroner or the Crown. Section 23 of *The Coroners Act* provides that:

> Counsel appointed by the Attorney General to act for the Crown at an inquest may attend thereat and may examine or cross-examine the witness called, and the coroner shall summon any witness required on behalf of the Crown.

In practice, Crown counsel attends at an inquest, leads the evidence the coroner wishes to present, and generally acts as counsel to the coroner. The coroner should be assisted by counsel, but because the coroner should be an official independent of government and should be so perceived, Crown counsel should act as the coroner's counsel and not as the Attorney General's representative. The Crown, in many instances, may be an interested party to the inquiry. In cases where the Crown is an interested party, such as where the death has occurred in an institution operated by the Department of Social Services, counsel to the coroner and counsel to the Crown should be separate.

Generally, it will be in order for the coroner to employ a Crown solicitor from the Attorney General's Department. In those cases where actions of the Crown may be called into question, however, the coroner should have the authority to employ independent counsel to assist him. The Attorney General should be allowed to employ counsel to represent the Crown where the Crown desires to be represented.

The Ontario legislation may serve as a model. It provides that:

> 30(1) Every coroner before holding an inquest shall notify the Crown attorney of the time and place at which it is to be held and the Crown attorney or a barrister and solicitor or any other person designated by him shall attend the inquest and shall act as counsel to the coroner at the inquest.
>
> (2) The Minister may be represented at an inquest by counsel and shall be deemed to be a person with standing at the inquest for the purpose.[136]

Finally, it should be noted that subsection 17(5) of *The Coroners Act* of Saskatchewan provides:

> (5) Where the inquest is with respect to a death resulting from an industrial accident in a plant, factory or mine:
>
> (a) a representative of a trade union that is the bargaining agent for employees at the plant, factory or mine, or counsel representing that trade union, may appear at the inquest and examine and cross-examine witnesses called at the inquest and may on behalf of any member of the trade union giving evidence at the inquest take the objection mentioned in subsection (2); and
>
> (b) a representative of a person operating the plant, factory or mine, or counsel representing such person, may appear at the inquest and examine and cross-examine witnesses called at the inquest and may on behalf of that person giving evidence at the inquest take the objection mentioned in subsection (2).

Such a specific provision is not necessary if any person with a substantial interest is given a right to participate in the inquest.

(b) Right to Notice

Participation in the inquest is a hollow right unless notice of the inquest is given to interested parties. There are three categories of persons who should be notified of an inquest by the coroner.

First, any person or body of persons should have the right to apply to the coroner to receive notice of any inquest directed by the coroner. Notification should not give the person notified an automatic right to standing at the inquest, but would give the opportunity to apply for standing, or simply to observe the proceedings.

Second, the coroner should notify the next-of-kin of the deceased parties known to him to have a substantial interest in the inquest, and parties whose conduct is likely to be called into question during the course of the inquest. As a model, consider section 29 of *The Coroners Act* of the Australian State of Queensland:

(2) The coroner may notify or cause to be notified in such manner and at such time as he sees fit any persons who, in the opinion of the coroner, have a sufficient interest in the subject or result of the inquest, of the holding of the inquest and of the time and place thereof.

(3) Every person whose conduct is likely, in the opinion of the coroner, to be called on question ... shall, unless in the opinion of the coroner it is impracticable to do so, be given reasonable notice in such manner as the coroner sees fit of the holding of the inquest and of the time and the place of the commencement thereof.[137]

Third, where the conduct of a party in relation to a death is called into question at an inquest, and the party is not present at the inquest and has not been given notice of it, the inquest should be adjourned pending notification if it is reasonably practical to do so. Such a party should, in fairness, be given an opportunity to participate. That practice is followed in England.[138] However, a failure to notify a party who should have been notified should not invalidate proceedings which have already taken place in whole or in part.

(c) Right to be Heard

At common law, it was the duty of anyone with knowledge of the circumstances of a death to appear at an inquest, and the coroner was obliged to receive the evidence of such persons.[139]

Persons who wish to be heard at an inquest should have a right to be heard, subject to the coroner's power to disallow the presentation of testimony which is vexatious, irrelevant or unnecessary. The right of a person to be heard where he has relevant testimony to offer is, like the right to standing, basic to the concept of fair procedure. It is applicable to a broader class of persons than those with some substantial interest in the inquest. The essential objective is the determination of the truth.

(d) Rights of Persons With Standing

Subsection (6) of section 17 of *The Coroners Act* now provides that persons with standing at an inquest may by themselves or by counsel examine and cross-examine any witness called at the inquest. That basic right should be preserved.

In addition, persons with standing should have the right to have witnesses subpoened by the coroner. The British Columbia statute provides that a person "whose interests may be affected by evidence likely to be adduced at an inquest" may "tender evidence and call witnesses" and "obtain from the coroner a summons directed to any witness whom he desires to call".[140]

For similar reasons, persons with standing should be permitted by themselves or through counsel to address the jurors at the conclusion of an inquest with respect to factual matters or with respect to recommendations which may be made by the jury. This practice is followed both in England[141] and Ontario.[142]

(e) Right of Witnesses To Counsel

Subsection (4) of section 17 of *The Coroners Act* provides that a witness "may be represented by counsel who may examine and cross-examine witnesses called at an inquest ...". Witnesses should continue to have the benefit of counsel to protect them from questioning beyond proper bounds and otherwise protect their interests.

(f) Rights of Persons Accused or Under Suspicion

At common law, no person could be compelled to testify against himself in a criminal proceeding. Since the coroner's inquest was considered a criminal court of record, a person accused of a crime in connection with the death could not be required to testify at an inquest.[143] The common law rule is given legislative expression in section 18 of *The Coroners Act*.

If the coroner's inquest is no longer to be a court of criminal record, it becomes a public inquiry under provincial jurisdiction. That being its status, persons accused of criminal conduct in connection with death would, in the absence of a specific provision to the contrary, very likely be compellable at coroner's inquests.[144] The protection contained in section 18 should be preserved. Without that protection, there is a danger that the Crown may use the coroner's inquest to elicit testimony from an accused person to facilitate his ultimate conviction.

Section 18 does not apply to persons under suspicion but not charged. This gives rise to the danger that the police may refrain from formally charging suspects until after the conclusion of the coroner's inquest, in order to use the inquest as an evidence-gathering mechanism.

The coroner must guard against this danger. As a general rule, coroners should refrain from holding inquests where criminal charges appear likely until it is reasonably certain that charges will not in fact be laid. As one observer has put it:

> In cases where criminal conduct is involved, the police should be urged to continue their investigations to a point where criminal charges are laid or they are satisfied that it would be useless to proceed futher.[145]

The danger is also lessened to some degree by the right of the suspect as witness to counsel, and by the coroner's power to disallow examination or cross-examination which is vexatious or irrelevant in the context of the inquest. The Ontario Law Reform Commission has noted[146] that if the power to commit for contempt is removed from coroners and given to superior court judges, a suspect could be relieved by a judge of any obligation to answer questions which were not relevant to the inquest but simply in pursuance of a criminal investigation.

Section 10 of *The Coroners Act* provides:

> (1) Where a person has been charged with a criminal offence arising out of a death, an inquest touching the death shall be held only on the direction of the Attorney General.
>
> (2) Where during an inquest a person is charged with a criminal offence arising out of the death, the coroner shall discharge the jury and close the inquest, and shall then proceed as if he had determined that an inquest was unnecessary, but the Attorney General may direct that the inquest be reopened.

The basic policy embodied in section 10 is sound. There may, however, be questions that remain unanswered but which are worthy of public scrutiny after criminal proceedings have concluded. Once they have concluded, coroners should have the discretion to order an inquest.

(g) Quashing the Verdict

Procedural rights have little meaning if there is no recourse when they are denied. Similarly, if the coroner allows a jury verdict which goes beyond the proper scope and, for example, makes allegations of criminal misconduct or negligence, individuals whose reputations have been adversely affected should have some method of redress. Procedures should exist to permit a court to quash a verdict arising out of an inquest on the basis of a

denial of procedural rights or on the ground that the verdict is not lawful. However, minor irregularities in the conduct of inquests should not result in a new inquest where no good purpose would be served. The breach complained of should be substantial in the sense that but for the breach the verdict could well have been different (for example, where standing is improperly denied to a person, and evidence might have been tendered by that person that could have altered the jury's view of the matter), or, where it is desirable in the interests of justice to hold a new inquest (for example, where there is a reasonable apprehension of bias on the part of the coroner).

8. Presiding Officer at Inquests

Coroners are not legally trained. Where, due to the nature of the case, there is likely to be a multiplicity of parties seeking standing or difficult questions concerning the admissibility of evidence or interpretation of law, provision should be made for the appointment of a lawyer or coroner experienced in such matters to preside at the inquest. In other cases, the nature of the evidence or the complexity of issues may make it desirable to replace the local coroner with someone with greater experience or expertise.

9. Consequential Amendment

Section 7 of *The Human Tissue Gift Act*[147] requires amendment. It reads:

> Where in the opinion of a physician, the death of a person is imminent by reason of injury or disease and the physician has reason to believe that section 4 of *The Coroners Act* may apply when death does occur and a consent under this Part has been obtained for a post-mortem transplant of tissue from the body, a coroner having jurisdiction, notwithstanding that death has not yet occurred, may give such directions as he thinks proper restricting the removal of such tissue after the death of the person.

The reference to section 4 will not apply with the enactment of the new *Coroners Act*.

RECOMMENDATIONS

The Commission's recommendations are embodied in a proposed new *Coroners Act*. Unlike the present *Act*, it is a complete code, specifying the duties and authority of coroners, and rules for conduct of inquests. It incorporates the conclusions reached in this report.

It should be noted that the present *Act* makes reference to the "Attorney General". Saskatchewan now has a Minister of Justice, but the *Criminal Code* designates the Attorney General as the officer responsible for administration of criminal justice in the province. The Minister of Justice continues to function as Attorney General for that purpose. Because the coroner retains, under the present *Act*, a role in the criminal justice system, the Minister to whom he reports continues to be designated as the Attorney General. If the Commission's recommendations are adopted, however, the coroner will no longer be directly concerned with criminal justice. For that reason, the Minister responsible for the coroner's system is designated as the "Minister of Justice" in the proposed *Act*. In the text of the report, however, the terminology of the existing *Act* was retained to avoid confusion.

AN ACT RESPECTING CORONERS

SHORT TITLE AND INTERPRETATION

Short Title

1. This Act may be cited as *The Coroners Act, 1984*.

Interpretation

2. In this Act:

"common law spouse"

(a) "common law spouse" in relation to a deceased person means a man or woman who is not legally married to the deceased but who has lived and cohabited with the deceased as his spouse immediately prior to the death of the deceased and who was known as the spouse of the deceased in the community in which they lived;

"criminal offence"

(b) "criminal offence" means an indictable offence under the *Criminal Code* (Canada);

"death"

(c) "death" includes a stillbirth within the meaning of *The Vital Statistics Act*;

"next of kin"

(d) "next of kin" means the mother, father, children, sister, brother, spouse or common law spouse of a deceased person;

Purpose

3. The purpose of this Act is to establish a coroner system in order to facilitate the investigation of deaths, and in particular to:

(a) determine the identity of deceased persons, and determine how, when, where and by what means they died;

(b) record statistics with respect to the causes of death;

(c) detect and discourage criminal conduct that may lead to death;

(d) uncover dangerous practices or conditions that may lead to death;

(e) educate the public with respect to dangerous practices and conditions;

(f) bring the facts surrounding deaths to the attention of the public when it is in the public interest to do so;

(g) provide for independent, impartial investigation into circumstances surrounding deaths;

(h) provide for public inquests into circumstances surrounding deaths; and

(i) preserve a record of the circumstances surrounding unexpected, unnatural or unexplained deaths.

OFFICERS

Chief Coroner

4.(1) The Lieutenant Governor in Council shall appoint a person as the Chief Coroner.

(2) Where the office of Chief Coroner is vacant or the Chief Coroner is unable by reason of illness, absence or other cause to carry out his duties, the Minister of Justice may designate another coroner to act as Chief Coroner until the Chief Coroner is able to resume his duties or resigns, or until a new Chief Coroner can be appointed.

Powers of Chief Coroner

5. The Chief Coroner has all the rights and powers of a coroner and has, in addition, the power to:

(a) administer this Act and the regulations;

(b) supervise all coroners in the performance of their duties;

(c) assist coroners in obtaining medical and other experts where necessary;

(d) establish and conduct programs for the instruction of coroners in their duties;

(e) bring findings and recommendations of coroners and juries to the attention of the appropriate persons, agencies or ministries of government;

(f) determine the qualifications for pathologists for the purposes of this Act;

(g) issue public reports;

(h) prepare, publish and distribute a code of ethics for coroners;

(i) make recommendations to the Lieutenant Governor in Council respecting the appointment of new or additional coroners; and

(j) recommend to the Lieutenant Governor in Council the suspension or removal of any coroner for misconduct, neglect of duty or inability to perform his duties.

Coroners

6.(1) The Lieutenant Governor in Council may appoint one or more persons to be coroners for the province.

(2) A coroner may by writing resign his office.

REPORTING OF DEATHS

Duty to notify

7.(1) Every person shall immediately notify a coroner or a police officer of any deaths of which he has knowledge that occurred under any of the following circumstances:

(a) deaths that occur as a result of violence, accident or suicide;

(b) deaths that occur from a cause other than disease or sickness;

(c) deaths that occur as a result of negligence, misconduct or malpractice on the part of others;

(d) deaths that occur suddenly and unexpectedly when the deceased was in apparent good health;

(e) deaths that occur without the attendance of a medical practitioner within 14 days prior to the death, during the last illness of the deceased;

(f) deaths that occur within ten days of an operative procedure or while under anesthesia or during recovery from anesthesia;

(g) deaths that occur due to:

(i) any disease or ill-health contracted or incurred by the deceased;

(ii) any injury sustained by the deceased; or

(iii) any toxic substance introduced into the deceased;

as a result of the employment or occupation of the deceased or in the course of his former employment or occupation;

(h) deaths that occur in the province under circumstances in which the body is not located because;

(i) the body or part of the body has been destroyed;

(ii) the body is in a place from which it cannot be recovered; or

(iii) the body has been removed from the province;

(i) stillbirths that occur without the presence of a medical practitioner.

(2) Every police officer who has been notified of a death under subsection (1) shall immediately notify a coroner of the death.

Duty of institutions to notify

8.(1) Where a person dies:

(a) while detained in a jail, military guardroom, remand centre, penitentiary, lock-up, a place where a person is held under a warrant of a judge, or a correctional facility within the meaning of *The Corrections Act*;

(b) while a patient in a facility, approved home or halfway house within the meaning of *The Mental Health Act*;

(c) while resident of a foster home, group home or place of safety within the meaning of *The Family Services Act*;

(d) while a resident of or in attendance at an institution or place that has as its primary aim or object the care, custody or treatment of children, or the education of children; or

(e) while an involuntary resident of any institution in the province or an inmate or patient in any institution specified in the regulations;

the person in charge of the institution, home, or facility shall immediately notify a coroner of the death.

(2) Where a person referred to in subsection (1) dies while not on the premises of that institution, home, or facility, the person in charge

of it shall immediately upon receiving notice of the death notify a coroner of the death.

(3) Where a person dies while in a hospital to which he was transferred from a place referred to in subsection (1), the person in charge of the hospital shall immediately notify the coroner of the death.

Duty of police to notify

9. Where a person dies while detained by or in the custody of a police officer, the police officer shall immediately notify a coroner of the death.

Duty of social workers to notify

10. Where a child dies while committed to, placed under or otherwise under the care, custody or supervision of the Minister of Social Services or the officers or employees of the Department of Social Services or the designates thereof, every officer or employee of the Department of Social Services who has knowledge of the death shall ensure that a coroner is notified.

INVESTIGATION

Coroner to investigate deaths

11.(1) Where a coroner receives information that there is in the locality within which he ordinarily exercises his office the body of a deceased person and he has reason to believe that the death occurred under circumstances that require the notification of a coroner, the coroner shall issue his warrant to take possession of the body, if the body is in the province, and shall conduct such investigation as is necessary.

(2) After the issue of a warrant no other coroner shall issue a warrant or interfere in the case except under the instructions of the Chief Coroner.

(3) A coroner who is notified of a death occurring without the attendance of a medical practitioner within 14 days prior to the death during the last illness of the deceased is not required to take possession of the body if he is satisfied that the death occurred from natural causes.

Disqualifications

12. A coroner shall not conduct an investigation or inquest where:

(a) the coroner or a partner, associate, employee or employer of the coroner has attended upon the deceased as a physician within six months prior to the death;

(b) the conduct of the coroner or of a partner, associate, employee or employer of the coroner might be called into question;

(c) the coroner is on the active or associated medical staff of, or is otherwise employed by the hospital where the death occurred and the treatment afforded in the hospital might be called into question;

(d) the coroner has performed a post-mortem examination of the body of the deceased; or

(e) the death occurred at a place, work or thing with respect to which the coroner has a financial interest.

Powers of coroner

13.(1) A coroner may in exercising his duties under this Act;

(a) take possession of and view any dead body;

(b) enter and inspect any place where a dead body is believed on reasonable grounds to be or to have been; and

(c) arrange for the disinterment of a body where authorized to do so by the Chief Coroner or the Minister of Justice.

(2) A coroner may, where he believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation or inquest:

(a) inspect any place in which the deceased person was or in which the coroner has reasonable grounds to believe the deceased person was prior to his death;

(b) secure the scene or area where death is believed on reasonable grounds to have occurred to enable investigation to be carried out for a period not exceeding 48 hours or for such other period as the Chief Coroner may authorize; and

(c) where authorized by a search warrant obtained pursuant to subsection (4), seize anything that he has reasonable grounds to believe is material to the investigation.

(3) The coroner may authorize a medical practitioner or police officer to exercise all or any of his powers under subsections (1) or (2), but where the power is conditional on the belief of the coroner, the belief must be that of the coroner personally.

(4) A judge of the Court of Queen's Bench who is satisfied by information upon oath that there are reasonable grounds to believe that there is in a building, receptacle or place anything that there are reasonable grounds to believe will afford evidence in respect of the circumstances of the death may issue a warrant authorizing a coroner to search for and seize any such thing.

(5) Where anything is seized under clause (2)(c), the coroner shall keep it in safe custody and shall return it to the person from whom it was seized as soon as practicable at the conclusion of the investigation or inquest, unless the coroner is authorized or required by law to dispose of it otherwise.

Post-mortem examination

14.(1) A coroner may at any time during an investigation or inquest issue his warrant for a post-mortem examination of the body, an analysis of the blood, urine or contents of stomach or intestines, or such other examination or analysis as is necessary.

(2) A post-mortem examination shall be performed by a pathologist.

(3) Any person who performs a post-mortem examination under subsection (2) may:

(a) where he has no reason to believe that the deceased has expressed an objection to the contrary;

(b) where he has no reason to believe that the surviving spouse or common law spouse, parent, child, brother, sister or personal representative objects to the body being so dealt with; and

(c) notwithstanding that a consent otherwise required by law is not given;

extract the pituitary gland and cause it to be delivered to any person or agency designated by the Chief Coroner for the use in the treatment of any person having a growth hormone deficiency.

Disinterment

15.(1) The Minister of Justice or Chief Coroner may order the disinterment of a body for the purposes of an investigation or inquest under this Act.

(2) Copies of an order made pursuant to subsection (1) shall be sent by registered mail at least 48 hours before disinterment to:

(a) the spouse or common law spouse of the deceased or, if there is no spouse or common law spouse, any of the adult next of kin resident in the province; and

(b) the owner or the person in charge of the cemetery or mausoleum where the body is buried or stored.

(3) Where the body of a person in respect of whom an investigation or inquest becomes necessary has been buried and the coroner is of the opinion that no good purpose would be served by disinterring the body, the Minister of Justice or Chief Coroner may in writing permit the coroner to conduct the investigation or inquest without disinterring the body.

Coroner may obtain assistance

16.(1) The police force having jurisdiction in the municipality in which the coroner is conducting the investigation or inquest shall make available to the coroner the assistance of police officers.

(2) A coroner may, with the consent of the Chief Coroner, obtain assistance of persons other than police officers or retain expert services for all or part of the investigation or inquest.

No obstruction of coroners

17. No person shall knowingly hinder, obstruct or interfere with a coroner in the performance of his duties or with a person authorized by a coroner in connection with an investigation or inquest.

Body to be preserved

18. No person who has reason to believe that a death occurred under circumstances that require it to be reported to a coroner or police officer shall in any way interfere with or alter the body or its condition unless the coroner so directs.

Scene to be preserved

19. Where a person has met death by violence in a wreck of a building, bridge, structure, embankment, airplane, motor vehicle, boat, machine or apparatus, the coroner may take charge of the wreckage and place police officers in charge of it to prevent disturbance of the wreckage until the coroner has made such examination as is necessary.

Public access to information

20. A coroner shall make available for public inspection at his office during normal business hours the following contents of his investigation:

(a) information of a factual nature, including information as to the identity of the deceased and findings made by the coroner as to how, when, where and by what means the deceased came to his death;

(b) the report of the pathologist, if any;

(c) the results of any other examinations or analyses of the body conducted during the course of the investigation; and

(d) a statement of the coroner indicating whether an inquest has been ordered.

Procedure where inquest unnecessary

21.(1) Where the coroner is, at the completion of an investigation, of the opinion that an inquest is not necessary, he shall issue his warrant to bury the body and shall as soon as practicable:

(a) transmit to the Chief Coroner a report setting forth his findings; and

(b) complete such information as may be required under *The Vital Statistics Act*.

(2) Notwithstanding that a report under subsection (1) has been transmitted, the Chief Coroner may direct the coroner or some other coroner to hold an inquest.

Right to request inquest

22.(1) Where a coroner decides that an inquest is unnecessary, a relative of the deceased or other interested person may in writing request that the coroner hold an inquest, and the coroner shall give him an opportunity to state his reasons in person, by his agent or in writing.

(2) The coroner shall in writing advise the person who requested the inquest of his final decision within 24 days of his receipt of the request, and shall include written reasons for his decision if he decides not to hold an inquest.

(3) Where the coroner decides not to hold an inquest, the person who requested it may, within 20 days after his receipt of the decision, request that the Chief Coroner review the decision.

(4) The Chief Coroner shall review a decision submitted to him pursuant to subsection (3) and give the person an opportunity to state his reasons in person, by his agent, or in writing; and, subject to section 26, the decision of the Chief Coroner is final.

Inquest a civil proceeding

23. The powers conferred on a coroner to conduct an inquest shall not be construed as creating a criminal court of record.

Where inquest required

24. A coroner shall hold an inquest where, after conducting an investigation, he is of the opinion that it is necessary to hold an inquest in order to:

(a) ascertain the identity of the deceased and determine how, when, where and by what means he came to his death where such facts are not adequately explained after investigation;

(b) inform the public of the circumstances surrounding a death where it is desirable to do so;

(c) bring dangerous practices or conditions to light and facilitate the making of recommendations to avoid preventable deaths; or

(d) educate the public as to dangerous practices or conditions in order to avoid preventable deaths.

Inquest where person detained

25. A coroner shall hold an inquest into the death of a person who has died while detained in a place referred to in clause 8(1)(a).

Minister of Justice may direct inquest

26.(1) The Minister of Justice may direct that the Chief Coroner or any other person hold an inquest into the death of a person, and the Chief Coroner or other person shall hold the inquest notwithstanding that a coroner has conducted an investigation, held an inquest or done any other act in connection with the death.

(2) Where an appointment is made under subsection (1), all the powers and duties that the coroner would have had at the inquest are vested in the Chief Coroner or other person, and the coroner has standing at the inquest.

Chief Coroner may direct other coroner to hold inquest

27. The Chief Coroner may direct a coroner to conduct an inquest notwithstanding that he or some other coroner has conducted an investigation, held an inquest or done any other act in connection with the death.

Coroner to transmit report

28. Where a coroner is required to hold an inquest, he shall transmit to the Chief Coroner a report in the form prescribed by the regulations, and shall issue his warrant for an inquest and hold an inquest as soon as it is practicable to do so.

Inquest into multiple deaths

29. Where two or more deaths appear to have occurred from the same event or from a common cause, the Chief Coroner may direct that one inquest be held in respect of all the deaths.

Jury

30. Every inquest shall be held with a jury composed of six jurors, any five of whom may return a verdict; and a verdict given by five jurors has the same effect as a verdict given by six jurors.

Selection of jury

31.(1) The coroner shall request the Chief Coroner to provide a list of the names of such number of persons as the coroner may specify who are resident in the geographical area specified by the coroner and who are qualified for and not excluded from service under *The Jury Act, 1981*.

(2) The Chief Coroner shall requisition from the person in charge of the registry maintained pursuant to subsection 13(1) of *The Saskatchewan Hospitalization Act* a list of names and addresses of persons in the number specified by the coroner who are resident within the geographical area indicated in the request, and no other information shall be transmitted.

(3) Notwithstanding any other Act, upon receipt of a requisition pursuant to subsection (2), the person in charge of the register described in subsection (2) shall randomly select the requisitioned number of names and addresses, and shall send the names and addresses, and no other information from the register, to the Chief Coroner.

(4) Immediately upon receipt of the names and addresses pursuant to subsection (2), the sheriff shall serve each person at the indicated address with:

(a) a Juror Information Return and Summons; and

(b) an Application for Relief from Jury Service;

in duplicate, together with an envelope addressed to the sheriff with postage prepaid.

(5) The provisions of *The Jury Act, 1981* respecting relief from jury service apply *mutatis mutandis*.

(6) The coroner shall select at random from the list the names of the persons who are present and who have not been disqualified by the coroner pursuant to section 32, until six jurors have been selected.

(7) Where a jury cannot be formed from the body of persons summoned to appear at the inquest, the coroner may order that a *tales de circumstantibus* be summoned and returned immediately for service.

Disqualification of jurors

32.(1) No officer, employee or inmate of a hospital, psychiatric facility, charitable institution, correctional facility, penitentiary, lock-up or other institution shall serve as a juror at an inquest in respect of a person whose death occurred in that place.

(2) No owner or employee of an owner of a building or premises in which any trade or business is carried on, and no owner or employee of that trade or business shall serve as a juror at an inquest in respect of a person whose death occurred in that place.

(3) No person not qualified for or excluded from service under *The Jury Act, 1981* shall serve as juror at an inquest.

(4) The coroner shall disqualify a person from being sworn as a juror if he believes that the person because of interest or bias might be unable to render a verdict in accordance with the evidence.

(5) No omission to observe the directions contained in this Act respecting the qualifications, exclusion or selection of jurors is a ground for impeaching the verdict rendered, unless the omission has resulted in a substantial miscarriage of justice.

Swearing of jurors

33. When the jurors are assembled, they shall be sworn by the coroner to diligently inquire into the death of the person in respect of whom the inquest is about to be held and to give a true verdict according to the evidence.

Inquest to be held in public

34.(1) Subject to subsection (2), an inquest shall be held in public.

(2) A coroner may hold all or part of an inquest *in camera* and order that all or part of the evidence not be published or broadcast where he is of the opinion that national security may be endangered.

(3) A coroner may order that witnesses be excluded from an inquest until they are called.

Procedure where criminal charge laid

35.(1) Where a person has been charged with a criminal offence arising out of a death, an inquest shall be held only on the direction of the Minister of Justice.

(2) No person charged with a criminal offence arising out of a death is compellable to give evidence at an inquest in respect of that death.

(3) Where during an inquest a person is charged with a criminal offence arising out of a death, the coroner shall, unless the Minister of Justice orders otherwise, discharge the jury and close the inquest, and shall reopen the inquest only on the direction of the Minister of Justice.

(4) Notwithstanding subsections (1) to (3), a coroner may hold an inquest where a person is charged with a criminal offence arising out of a death and the charge or an appeal from any conviction or acquittal has been finally disposed of or the time for taking an appeal has expired; and the person so charged is a compellable witness at the inquest.

Procedure where criminal charge likely

36. A coroner shall delay the holding of an inquest where it appears likely that a person will be charged with a criminal offence arising out of the death unless directed by the Minister of Justice to hold an inquest.

Orders where criminal charge

37. Where a person has been charged or it appears that a person may be charged with a criminal offence arising out of the death, the coroner may order that no evidence be published or broadcast without his authority until:

(a) a charge is laid and the charge or an appeal from any conviction or acquittal of the offence has been finally disposed of;

(b) the time for taking an appeal has expired; or

(c) it appears that no charge will be laid.

Orders where death self-inflicted

38.(1) Where at the commencement or during the course of an inquest it appears that the death may have been self-inflicted, the coroner may order that no report of the proceedings be published or broadcast until a verdict is rendered.

(2) Where the verdict is that a death was self-inflicted, the coroner may order that no report of the proceedings be published or broadcast without the authority of the coroner other than the name, address and occupation of the deceased, the fact that an inquest has been held, and that the death was found to have been self-inflicted.

Standing

39. A coroner may grant standing at an inquest to any person whom the coroner considers to have a substantial interest in the proceedings.

Notice to Department of Justice

40.(1) A coroner shall notify the Department of Justice of the time and place at which the inquest is to be held.

(2) The Minister of Justice has standing at an inquest and may be represented by counsel.

Request for counsel

41.(1) Upon the request of a coroner, the Minister of Justice shall appoint Crown counsel designated by him to attend at an inquest and act as counsel to the coroner.

(2) Where in the opinion of the coroner it is in the public interest to retain counsel other than Crown counsel, the coroner may retain some other counsel.

Notice of inquest

42.(1) Any person may make a request in writing to the coroner in charge of an investigation to be notified of the time and place of an inquest, and the coroner shall give notice in writing of the time and place of the inquest to that person.

(2) The coroner shall give notice in writing of the time and place of the inquest to:

(a) the next of kin of the deceased;

(b) persons who in the opinion of the coroner have a substantial interest in the inquest; and

(c) persons whose conduct is in the opinion of the coroner likely to be called into question at the inquest;

of whom the coroner has knowledge.

(3) Where the conduct of a person who has not been notified of and is not present at the inquest is brought into question, the coroner shall adjourn the inquest and notify that person if it is reasonably practicable to do so.

(4) Failure to notify a person of an inquest does not invalidate the proceedings.

Right to be heard

43.(1) The coroner shall hear any person who wishes to give evidence at an inquest so long as the evidence is not vexatious or irrelevant.

(2) A person who has standing at an inquest may:

(a) be represented by counsel or an agent;

(b) call and examine witnesses, and cross-examine witnesses;

(c) obtain from a coroner a summons directed to any witness desired to be called; and

(d) present arguments and submissions, and address the jury at the conclusion of the evidence.

(3) A witness at an inquest may be represented by counsel who may examine and cross-examine witnesses called at the inquest.

Coroner may summon witnesses

44.(1) A coroner may require any person by summons to:

(a) give evidence on oath or by affirmation at an inquest; or

(b) produce in evidence at an inquest any document or thing in his control that the coroner may specify;

that is relevant to the subject matter of the inquest and admissible.

(2) Service of the summons shall be effected by personal service of a copy of the summons by a police officer.

(3) Where a witness who is required to attend an inquest is confined to a place referred to in clause 8(1)(a), the coroner may in writing order that the witness be brought before him in order to testify at the inquest and direct in the order the manner in which the witness is to be kept in custody until his return to the place of his detention.

Coroner to administer oaths

45. The coroner may administer oaths and affirmations to jurors, witnesses and interpreters according to the practice in the Court of Queen's Bench.

Jury may question witnesses

46. Members of the jury may ask questions of the witnesses and shall view the body where directed by the coroner to do so.

Warrant for arrest

47.(1) Upon proof to the satisfaction of a judge of the Court of Queen's Bench of a summons upon a person:

(a) who has failed to attend or to remain in attendance at an inquest in accordance with the requirements of the summons; and

(b) whose presence is material to the inquest;

the judge may issue a warrant to cause the witness to be apprehended anywhere within the province and be brought before the inquest.

(2) The coroner may certify that the facts relied on to establish that the presence of the person summoned is material to the inquest, and the certificate may be accepted by the judge as proof of those facts.

Contempt proceedings

48.(1) Where a person without lawful excuse:

(a) on being duly summoned as a witness or a juror at an inquest, fails to attend or remain in attendance at the inquest;

(b) being in attendance as a witness at an inquest, refuses to take an oath or to make an affirmation or to produce any document or thing in his control or to answer any question; or

(c) does any other thing that would, if the inquest had been a court of law having power to commit for contempt, have been contempt of that court;

the coroner may state a case to a judge of the Court of Queen's Bench setting out the facts.

(2) A court to which a case has been stated pursuant to subsection (1) may, on application of and in the name of the coroner, inquire into the matter and, after hearing any witnesses who may be produced against or on behalf of that person and after hearing any statement that may be offered in defence, the court may punish or take steps for the punishment of that person in like manner as if he had been guilty of contempt of the court.

Coroner to maintain order

49. The coroner may make orders or give directions as he considers necessary for the maintenance of order at the inquest, and may call upon a police officer to enforce such orders or directions.

Evidence

50.(1) A coroner at an inquest may:

(a) subject to subsection (2), admit any oral testimony, document or other thing as evidence, whether or not it is admissible as evidence in a judicial proceeding;

(b) exclude anything that he considers to be unduly repetitious or that in his opinion fails to meet the standards of proof that are commonly relied on by reasonably prudent men in the conduct of their own affairs;

(c) comment on the weight to be given any evidence; or

(d) limit examination or cross-examination of a witness where it is vexatious or irrelevant.

(2) Nothing in this section derogates from:

(a) the provisions of any Act expressly limiting the extent to or purposes for which any oral testimony, documents or other things may be admitted or used in evidence; or

(b) any privilege under the law of evidence.

Documents

51.(1) A copy of a document or other thing may be admitted as evidence at an inquest if the coroner is satisfied as to its authenticity.

(2) Where a document has been admitted as evidence at an inquest, the coroner or, with the leave of the coroner, the person who produced it or is entitled to it, may cause the document to be photocopied, and the coroner may:

(a) authorize the photocopy to be admitted in evidence in place of the document, and order the release of the document; or

(b) furnish to the person who produced or is entitled to the document a photocopy of it certified by the coroner.

Reports

52.(1) The coroner may accept a report, medical report, plan, sketch, photograph or other document containing information of a factual nature in place of the oral testimony of the maker of that document, and the document is, without further proof, evidence of the facts stated in it.

(2) The coroner may, at the request of a person or juror who has a sufficient reason to question the maker of the document, require the maker of it to attend and give evidence at the inquest.

Adjournment

53.(1) An inquest may be adjourned from time to time by the coroner on his own motion or where it is shown to the satisfaction of the coroner that the adjournment is required to permit an adequate hearing to be held.

(2) Where a juror, by reason of illness, death or absence from the province, does not attend at the resumption of an adjourned inquest, the coroner may proceed with the inquest if at least five jurors are present.

Coroner unable to continue

54. Where for any cause a coroner cannot complete an inquest, another coroner may complete it and may act on the evidence as if it had been given before him.

Recording of evidence

55.(1) Subject to subsection (2), the coroner shall put into writing the evidence of each witness, or so much of it as is material, and the deposition shall be signed by the witness and the coroner.

(2) Where the coroner so directs, the evidence or any part of it shall be taken in shorthand by a stenographer appointed by the coroner.

(3) A stenographer shall take an oath that he will truly and faithfully report the evidence, and the transcript of the evidence shall be signed by the coroner and accompanied by an affidavit of the stenographer that it is a true report of the evidence.

(4) The evidence taken by a stenographer need not be transcribed unless ordered by the Minister of Justice or counsel appointed by him to act for the Crown at the inquest, by the Chief Coroner or by any person who requests a transcript and pays to the stenographer the fee ordinarily payable for transcripts of judicial proceedings.

(5) A coroner may employ an interpreter at an inquest.

Jury verdict

56.(1) The jury shall, at the conclusion of the inquest, retire to consider the evidence and determine the identity of the deceased and how, when, where and by what means he came to his death.

(2) The jury may make any recommendation that it considers to be of assistance in preventing similar deaths.

(3) The jury shall not make any finding of legal responsibility or express any conclusions of law.

(4) The coroner shall not accept a jury verdict or a portion of a jury verdict that makes any finding of legal responsibility or expresses any conclusion of law, and may order that such a verdict or portion of a verdict not be published or broadcast.

Report to Chief Coroner

57. A coroner shall at the conclusion of an inquest forward to the Chief Coroner the verdict and any recommendations of the jury, a list of fees to be paid to the jurors and witnesses and a transcript of the evidence at the inquest if it has been transcribed.

Procedure where jury disagrees

58.(1) If the jury cannot agree by a majority upon a verdict, the coroner may discharge the jury after obtaining any findings of facts that they have been able to agree upon.

(2) The coroner shall submit the evidence taken at the inquest, together with any findings of fact that the jury has been able to agree upon, to the Chief Coroner.

(3) The Minister of Justice or Chief Coroner may direct the coroner to summon another jury and hold another inquest, or to take such other action as the Minister of Justice or Chief Coroner may direct.

Coroner to furnish particulars of death

59. Immediately upon the close of an investigation or inquest, the coroner shall send to the Director of Vital Statistics such information as may be required under *The Vital Statistics Act*.

Coroner may authorize burial prior to inquest

60. A coroner who intends to hold an inquest may by his warrant authorize the burial of the body pending completion of the medical certificate of death.

Court may quash verdict

61.(1) A person who has a substantial interest in an inquest may apply to a judge of the Court of Queen's Bench for an order quashing the verdict of the jury on the basis of:

(a) a denial of procedural rights or an irregularity in the conduct of the inquest; or

(b) that the verdict makes a finding of legal responsibility or expresses a conclusion of law.

(2) The judge may quash the verdict of the jury where he is satisfied that the denial of procedural rights or an irregularity was substantial or that it is otherwise necessary and desirable in the interests of justice to quash the verdict.

(3) The judge may quash the verdict or a portion of the verdict where he is satisfied that the verdict or a portion of the verdict makes a finding of legal responsibility or expresses a conclusion of law.

(4) A judge may, on quashing a verdict, order that a second inquest be held before the same coroner or before any other coroner.

GENERAL

Special permit for cremation, removal

62.(1) No person shall:

(a) cremate a body;

(b) transport or remove a body from the province; or

(c) bury or otherwise dispose of the body of a person who has died outside the province that has been brought into the province for burial or other disposition;

unless a special permit is obtained from a coroner for the cremation, removal or burial.

(2) A coroner shall issue a special permit for a cremation, removal or burial if he is satisfied that it is not necessary to investigate the death.

Radio-nuclide batteries

63.(1) The coroner shall remove or authorize the removal of any long-lived radio-nuclide battery or other device present in a body prior to the issue of a permit to cremate the body.

(2) Any person who knows or believes that a long-lived radio-nuclide battery or other device is present in a body shall notify the coroner of it.

(3) Where a coroner has been notified or has reason to believe that a long-lived radio-nuclide battery or other device is present in a body, he shall remove or authorize the removal of it whether or not any investigation is conducted under this Act, and shall deliver it to a person licensed to deal with it by the Atomic Energy Board.

Protection from civil liability

64. A coroner, or an agent acting on his behalf, is not liable for loss caused by anything done or not done by him in the performance of his duties or in respect of a matter in which he lacked or exceeded his jurisdiction unless it is proved that he acted in bad faith or without reasonable and probable cause.

Offence

65. Every person who contravenes this Act is guilty of an offence punishable on summary conviction and is liable to a fine of not more than five hundred dollars.

Regulations

66. For the purpose of carrying out this Act to its true intent, the Lieutenant Governor in Council may make regulations:

(a) defining any word or expression used but not defined in this Act;

(b) prescribing the remuneration or allowances to be paid to the Chief Coroner, coroners, jurors, witnesses, interpreters and other persons;

(c) prescribing forms and providing for their use;

(d) prescribing additional rules and procedures for inquests; and

(e) respecting any other matter considered necessary for carrying out the purposes and provisions of this Act.

Appropriation

67. Sums required for the purposes of this Act shall be paid out of moneys appropriated by the Legislature for the purpose.

Repeal of common law

68. The common law as it relates to the functions, powers and duties of coroners is repealed.

Officers, proceeding continued

69.(1) Every person holding office as Chief Coroner or coroner immediately prior to the coming into force of this Act shall continue to hold office and shall be deemed to have been appointed pursuant to the provisions of this Act.

(2) Every proceeding and process initiated, pending or heard in part immediately prior to the coming into force of this Act shall be continued as if it had been initiated under this Act, and this Act applies *mutatis mutandis*.

(3) Reference in any Act to a coroner or a proceeding under *The Coroners Act* shall be deemed to be a reference to this Act or to the equivalent proceeding under it, and this Act so far as possible applies *mutatis mutandis*.

70. *The Coroners Act* is repealed.

71. This Act comes into force on a day to be fixed by proclamation of the Lieutenant Governor.

An Act to amend *The Mental Health Act*

Short Title

1. This Act may be cited as *The Mental Health Amendment Act, 1984*.

Section 47 repealed

2. Section 47 of *The Mental Health Act* is repealed.

3. This Act comes into force on the day *The Coroners Act, 1984* comes into force.

An Act to amend *The Human Tissue Gift Act*

Short Title

1. This Act may be cited as *The Human Tissue Gift Amendment Act, 1984*.

New Section 7

2. Section 7 of *The Human Tissue Gift Act* is repealed and the following substituted:

Coroner's direction

"7. Where in the opinion of a physician the death of a person is imminent by reason of injury or disease and the physician has reason to believe that the death, when it does occur, is one that will be required to be reported to a coroner under *The Coroners Act, 1984*, and if a consent under this Part has been obtained for a post-mortem transplant of tissue from the body, the physician shall notify a coroner and the coroner shall give such directions as he thinks proper respecting the removal of the tissue after the death of the person."

3. This Act comes into force on the day *The Coroners Act, 1984* comes into force.

APPENDIX

Revision of *The Vital Statistics Act*

As noted in this report, the proposed *Coroners Act* can be implemented without change in the requirements for registration of death provided in *The Vital Statistics Act*. However, the Commission has discussed amendment of *The Vital Statistics Act* with the Division of Vital Statistics. Amendments to the *Act* are being prepared by the Division. These amendments will provide additional safeguards to ensure that investigations are conducted by coroners in appropriate cases. The proposed *Coroners Act* is designed to facilitate the forthcoming amendments to *The Vital Statistics Act*.

The recommendations for amendment of *The Vital Statistics Act* included here reflect the Commission's understanding of the basic approach of the Division to revision of the *Act*. They indicate the changes which the Commission has anticipated in drafting the proposed *Coroners Act*.

RECOMMENDATIONS

1. *The Vital Statistics Act* should provide that:

    1. Coroners throughout Saskatchewan be appointed to serve as registrars of stillbirths and deaths.

    2. Where a death occurs in a hospital, nursing home or custodial institution, the body shall not be released by the institution for burial or other disposition until a fully completed Medical Certificate of Death or an interim Medical Certificate of Death has been completed by a medical practitioner or coroner.

    3. If a death occurs under circumstances which require reporting of the death to a coroner, the authorization of the coroner shall be required before the body can be released for burial or other disposition.

    4. If a death is not reportable to a coroner and the medical practitioner who confirms the fact of death is not the attending physician or the attending physician cannot immediately determine the cause of death, the body may be released for burial by completion of an interim Medical Certificate of Death where, in place of the cause of death, the physician indicates "this body is released for burial — notification of coroner is not required".

    5. Where a body has been released for burial under item 4, the fully completed Medical Certificate of Death must be filed with the local registrar within 14 days after the date of death or as soon as possible thereafter.

    6. If a coroner wishes to release a body for burial prior to determining the cause of death, he may do so by completing the Medical Certificate of Death and entering thereon, in place of the cause of death, the words "this body is released for burial".

    7. Where a coroner releases a body for burial under item 6, he must forward the fully completed Medical Certificate of Death to the Director of Vital Statistics within two days of determining the cause of death or completing the investigation.

8. Where a death occurs in a private home, a coroner must be notified unless the attending physician or other medical practitioner attending after the death has confirmed the fact of death and has left with the body a completed Medical Certificate of Death for the funeral director.

9. No person shall embalm, bury or otherwise dispose of the body of a person who dies in the province unless the death has been registered and a Burial Permit obtained.

10. The Registration of Death consists of two forms:

    Form "A" — This includes the personal particulars of the deceased and the details of burial. It is completed by the funeral director with the assistance of a family member or other informant.

    Form "B" — Medical Certificate of Death. This is completed by the attending physician or coroner and is given to the funeral director.

    In order to obtain a Burial Permit, the funeral director is to deliver the Registration of Death (consisting of Form "A" and Form "B") to the coroner serving as a registrar of deaths.

11. Stillbirths which occur in hospitals shall be treated in the same manner as births and deaths which occur in hospitals. Stillbirths which occur outside of the hospital setting must automatically be reported to a coroner. In these cases, the registration will be completed in the same manner as that of a death reportable to a coroner.

FOOTNOTES

1. On the early office, see R. F. Hunnisett, *The Medieval Coroner*, (Cambridge University Press, 1961); G. Thurston, *Coronership*, (Chichester and London: Barry Rose Publishers, 1976); J. D. J. Havard, *The Detection of Secret Homicide*, (London: MacMillan & Co. Ltd., 1960).
2. Havard, *supra* note 1, at 19.
3. *Ibid.* at 21.
4. J. N. Adler, "Coroners' Inquests: The Impact of Watts" (1967), 15 U.C.L.A. L. Rev. 97, at 99-100.
5. Havard, *supra* note 1, at 2.
6. *Northwest Territories Act*, R.S.C. 1886, c. 50, s. 11 (see R.S.S. 1978, Appendix); 4 & 5 Edw. 7, c. 42, s. 16 (see R.S.S. 1978, Appendix).
7. S.S. 1906, c. 21.
8. *Ibid.*, ss. 2-5
9. *Ibid.*, s. 4.
10. *Ibid.*, s. 5.
11. *Ibid.*, s. 12.
12. S.S. 1912-13, c. 18.
13. S.S. 1921-22, c. 27.
14. S.S. 1936, c. 26.
15. *Ibid.*, s. 5.
16. S.S. 1978, c. 8, s. 2.
17. *Ibid.*, s. 9.
18. *Ibid.*, s. 8.
19. S.S. 1979-80, c. 57, s. 3.
20. R.S.S. 1978, c. C-38, amended R.S.S. 1978 (Supp.) c. 9; S.S. 1979, c. 69; S.S. 1979-80, c. 57; S.S. 1979-80, c. 58; S.S. 1979-80, c. 96, (hereafter *The Coroners Act*).
21. *Ibid.*, s. 4.
22. *Ibid.*, s. 5(1).
23. *Ibid.*, s. 7(1).
24. *Ibid.*, ss. 7(2) and 8.
25. *Ibid.*, s. 9.
26. *Ibid.*, s. 11.
27. *Ibid.*, s. 12.
28. *Ibid.*, s. 14.
29. *Ibid.*, s. 16(1).
30. *Ibid.*, 23.
31. *Ibid.*, s. 24(1).
32. S.C. 1892, c. 29, s. 940; now R.S.C. 1970, c. C-34, s. 506(3).
33. R.S.C. 1970, c. C-34, s. 462.
34. *R.* v. *Hicks*, [1945] 3 W.W.R. 674 (Sask. K.B.); but see *contra*, *Faber* v. *The Queen*, [1976] 2 S.C.R. 9.
35. Quebec: *Coroners Act*, R.S.Q. 1977, c. C-68; Manitoba: *The Fatalities Inquiries Act*, C.C.S.M., c. F-52; Nova Scotia: *The Fatality Inquiries Act*, R.S.N.S. 1967, c. 101.
36. *Supra* note 20, s. 20(1).
37. R.S.S. 1965, c. 113, s. 18.
38. S.S. 1966, c. 94, s. 5.
39. *Coroners Act*, R.S.O. 1980, c. 93; *Coroners Act*, R.S.B.C. 1979, c. 68.
40. R.S.O. 1980, c. 93, s. 2(2).
41. Havard, *supra* note 1, at 182-4.

42 British Columbia: *Coroners Act*, R.S.B.C. 1979, c. 68; Saskatchewan: *The Coroners Act*, R.S.S. 1978, c. C-38; Ontario: *Coroners Act*, R.S.O. 1980, c. 93; Quebec: *Coroners Act*, R.S.Q. 1977, c. C-68; New Brunswick: *Coroners Act*, R.S.N.B. 1973, c. C-23; Northwest Territories: *Coroners Ordinance*, R.O.N.W.T. 1974, c. C-16; Yukon: *Coroners Ordinance*, R.O.Y.T. 1971, c. C-18.

43 Nova Scotia: *The Fatality Inquiries Act*, R.S.N.S. 1967, c. 101; Alberta: *Fatality Inquiries Act*, R.S.A. 1980, c. F-6.

44 *Coroners Act*, S.P.E.I. 1957, c. 10; *Death Inquiries Act*, R.S.P.E.I. 1974, c. D-2.

45 *The Summary Proceedings Act*, S. Nfld. 1979, c. 35.

46 C. Granger "Crime Inquiries and Coroner's Inquests: Individual Protection in Inquisitorial Proceedings" (1977), 9 Ottawa L. Rev. 441, at 453.

47 Ontario Law Reform Commission, *Report on the Coroner System in Ontario* (1971), at 24.

48 *Ibid.*, at 8.

49 "The Rigors of Mortis: Participation by Counsel at Coroner's Inquests" (1970), 43 S. Cal. L. Rev. 329, at 333.

50 Information and statistics relating to coroners in Saskatchewan have been obtained from J. Stewart MacMillan, the chief coroner for Saskatchewan.

51 Shulman, *Coroner*, (Fitzhenry & Whiteside, 1975), at 6.

52 J. Pfaff & B. A. Mackenzie, "The Montana Coroner System: An Archaic Inadequacy in Need of Reform" (1975), 36 Montana L. Rev. 1, at 1.

53 H. H. Pilling "The Brodrick Report: A General View", [1972] Crim. L. Rev. 70, at 71.

54 *Coroners (Amendment) Act, 1926*, 16 & 17 Geo. 5, c. 59, s. 1(1).

55 Havard, *supra* note 1, at 206.

56 E. D. Williams, "Coroner's Practice — I" (1969), 113 Sol. J. 726.

57 *Coroners Act*, R.S.O. 1980, c. 93, s. 3(1).

58 S.S. 1978, c. 8, s. 2.

59 *Genois* v. *The King* [1938] 1 D.L.R. 807 (Ex. Ct.).

60 Thurston, *supra* note 1, at 15.

61 Bennet, "The Coroner's Office in Ontario" in *The Role of the Inquest in Today's Litigation*, (Toronto: Department of Continuing Education, The Law Society of Upper Canada, 1975).

62 *The Ombudsman Act*, R.S.S. 1978, c. 0-4.

63 *Supra*, note 47, at 38-44.

64 *Ibid.*, at 64.

65 R.S.S. 1978, c. 7(2).

66 *Ibid.*, s. 8.

67 *Ibid.*, s. 11.

68 *Ibid.*, s. 19.

69 *Ibid.*, s. 21(2).

70 *Ibid.*, s. 24(3).

71 Havard, *supra* note 1, at 23.

72 R.S.S. 1978, c. V-7.

73 6 & 7 Will. 4, c. 86.

74 Havard, *supra* note 1, at 45-48.

75 *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 10(2)(b). See also the *Coroners Act*, R.S.O. 1980, c. 93, s. 10(1)(d).

76 *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 10(2)(c); *The Summary Proceedings Act*, S. Nfld. 1979, c. 35, s. 22(1)(e); *Coroners Act*, R.S.B.C. 1979, c. 68, s. 9(1)(a).

77 R.S.S. 1978, c. V-7.

78 Sask. Reg. 169/66.

79 Sask. Reg. 176/77.

80 S.I. No. 1696, Reg. 82 (1), as amended by 1960, S.I. No. 1604 (U.K.).

81 *Coroners Act*, R.S.B.C. 1979, c. 68, s. 9(1)(e).

82 *Fatality Inquiry Act*, R.S.A. 1980, c. F-6, s. 10(2)(h).

83 Sask. Reg. 176/77.

84. *Fatality Inquiry Act*, R.S.A. 1980, c. F-6, s. 10(2)(f).

85. *Ibid.*, s. 10(2)(j).

86. *Ibid.*, s. 18.

87. *Supra*, note 20, s. 9(1).

88. Prisoners in custody of peace officer: B.C. Alta., Man., Ont., N.B., N.S., Nfld., P.E.I.; deaths in mental institutions: B.C., Ont., Alta., Que., N.B.; deaths in homes for the elderly: B.C., Ont., P.E.I.; child deaths in institutions: Alta., Ont., N.S.

89. R.S.S. 1978, c. M-13.

90. *Coroners Act*, R.S.B.C. 1979, c. 68, s. 12; *Fatality Inquiry Act*, R.S.A. 1980, c. F-6, s. 17; *Coroners Act*, R.S.O. 1980, c. 93, s. 11.

91. *Fatality Inquiry Act*, R.S.A., 1980, c. F-6, s. 16.

92. *Ibid.*, B.C.: s. 14; Alta.: s. 16; Ont.: s. 13.

93. *The Vital Statistics Act*, R.S.S. 1978, c. V-7, s. 18(10).

94. *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 15.

95. *Supra*, note 20, s. 5(1).

96. R.S.S. 1978, c. I-11.

97. Thurston, *supra* note 1, at 65.

98. *Coroners Act*, R.S.B.C. 1979, c. 68, s. 16; *Coroners Act*, R.S.O. 1980, c. 93, s. 16.

99. *Constitution Act*, 1982, Schedule B; enacted by the *Canada Act, 1982* (U.K.), c. 11.

100. *Coroners Act*, R.S.B.C. 1979, c. 68, s. 16(3); *Coroners Act*, R.S.O. 1980, c. 93, s. 9.

101. Havard, *supra* note 1, at 146-69.

102. R.S.A. 1980, c. F-6, s. 26(2).

103. Thurston, *supra* note 1, at 85.

104. *Supra* note 47, at 81.

105. J. C. E. Wood, "Discovering the Ontario Inquest" (1967), 5 Osgoode Hall L.J. 243, at 248-9.

106. *Garnett* v. *Ferrand* (1827), 108 E.R. 576.

107. *The Summary Proceedings Act*, S. Nfld. 1979, c. 35, s. 26(2).

108. *Coroners Act*, R.S.N.B. 1973, c. C-23, s. 21.

109. *Supra*, note 47, at 91.

110. (1968), vol. 1, at 492-4.

111. *Coroners Act*, R.S.O. 1980, c. 93, s. 32.

112. *Coroners Act*, R.S.B.C. 1979, c. 68, s. 29.

113. *Coroners Act, 1951*, No. 73, s. 21 (N.Z.).

114. *Constitution Act, 1982*, Schedule B, s. 11(d).

115. "Coroner's Inquest — The Heighes Case" 19 Chitty's L.J. 296, at 300.

116. R.S.O. 1980, c. 93.

117. G. H. R. Cooper, "Investigation" in *The Role of the Inquest in Today's Litigation*, *supra* note 61, at 10.

118. [1930] 2 K.B. 29.

119. *Ibid.*, at 34.

120. S.S. 1980-81, c. J-4.1.

121. *Coroners Act*, R.S.O. 1980, c. 93, s. 34(6).

122. *R.* v. *Little*; *R.* v. *Miller*, [1926] 2 W.W.R. 762 (Man. K.B.).

123. *Supra* note 110 at 495.

124. *Coroners Act*, R.S.O. 1980, c. 93, s. 51.

125. *Ibid.*, s. 47.

126. Wood, *supra* note 105, at 257.

127. *Coroners Act*, R.S.B.C. 1979, c. 68, ss. 42, 44

128. *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 40.

129. *Coroners Act*, R.S.O. 1980, c. 93, s. 44.

130. *Coroners Act*, R.S.B.C. 1979, c. 68, s. 39(5).

131. *Coroners Act*, R.S.O. 1980, c. 93, s. 41; *The Coroners Act*, R.S.S. 1978, c. C-38 as amended, s. 17(6).

132. (1980), 5 W.C.B. 131 (Ont. H.C.J.).

133. Thurston, *supra* note 1, at 107.

134. *Ibid.*

135. *The Coroners Act, 1960*, No. 2, s. 17 (N.S.W.).

136. *Coroners Act*, R.S.O. 1980, c. 93, s. 30.

137. *Coroners Act of 1958*, 7 Eliz. 2, No. 32 (Queensland).

138. Coroners Rules, 1953, S.I. No. 205, Rules 20, 26.

139. *Chartier* v. *Attorney General of Quebec* (1979), 9 C.R. (3d) 97 (S.C.C.).

140. *Coroners Act*, R.S.B.C. 1979, c. 68, s. 37(1).

141. E. A. Williams, "Coroners Practice — II" (1969), 113 Sol. J. 744, at 745.

142. *Supra* note 116, at 301.

143. *Batary* v. *Attorney General for Saskatchewan*, [1965] S.C.R. 465.

144. *Royal Amercian Shows Inc.* v. *Laycraft J.*, [1978] 2 W.W.R. 169 (Alta. S.C.T.D.).

145. B. Affleck, "The Role of the Crown at the Inquest", *The Role of the Inquest in Today's Litigation*, *supra* note 61, at 21.

146. *Supra* note 47, at 100.

147. R.S.S. 1978, c. H-15.